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By CERTIFICATE OF NEED PROGRAM at 5:00 pm, Jan 29, 2021

CN21-56

# Hospice Agency Certificate of Need Application Packet

**Contents:**



**Application submission must include:**

- One electronic copy of your application, including any applicable attachments – no paper copy is required.
- A check or money order for the review fee of $21,968 payable to Department of Health.

Include copy of the signed cover sheet with the fee if you submit the application and fee separately. This allows us to connect your application to your fee. We also strongly encourage sending payment with a tracking number.

Mail or deliver the application and review fee to:

**Mailing Address:**

Department of Health
Certificate of Need Program
P O Box 47852
Olympia, Washington 98504-7852

**Other Than By Mail:**

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, Washington 98501

**Contact Us:**
Certificate of Need Program Office 360-236-2955 or FSLCON@doh.wa.gov.

# Application Instructions

The Certificate of Need Program will use the information in your application to determine if your project meets the applicable review criteria. These criteria are included in state law and rules. Revised Code of Washington (RCW) 70.38 and Washington Administrative Code (WAC) 246-310.

**General Instructions:**

- Include a table of contents for application sections and appendices/exhibits
- Number **all** pages consecutively
- Make the narrative information complete and to the point.
- Cite all data sources.
- Provide copies of articles, studies, etc. cited in the application.
- Place extensive supporting data in an appendix.
- Provide a detailed listing of the assumptions you used for all of your utilization and financial projections, as well as the bases for these assumptions.
- Under no circumstance should your application contain any patient identifying information.
- Use **non-inflated** dollars for **all** cost projections
- **Do not** include a general inflation rate for these dollar amounts.
- **Do** include current contract cost increases such as union contract staff salary increases. You must identify each contractual increase in the description of assumptions included in the application.
- **Do not** include a capital expenditure contingency.
- If any of the documents provided in the application are in draft form, a draft is only acceptable if it includes the following elements:
  a. identifies all entities associated with the agreement,
  b. outlines all roles and responsibilities of all entities,
  c. identifies all costs associated with the agreement,
  d. includes all exhibits that are referenced in the agreement, and
  e. any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

**Do not skip any questions in this application. If you believe a question is not applicable to your project, explain why it is not applicable**.

**Answer the following questions in a manner that makes sense for your project. In some cases, a table may make more sense than a narrative. The department will follow up in screening if there are questions.**

Program staff members are available to provide technical assistance (TA) at no cost to you before submitting your application. While TA is not required, it is highly recommended and can make any required review easier. To request a TA meeting, call 360-236-2955 or email us at FSLCON@doh.wa.gov.

# Certificate of Need Application
# Hospice Agency

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Certificate of Need applications must be submitted with a fee in accordance with Washington Administrative Code (WAC) 246-310-990.

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Application is made for a Certificate of Need in accordance with provisions in Revised Code of Washington (RCW) 70.38 and WAC 246-310, rules and regulations adopted by the Washington State Department of Health. I attest that the statements made in this application are correct to the best of my knowledge and belief.

| | |
|---|---|
| Signature and Title of Responsible Officer<br><br>*Mary Kofstad*<br><br>**Mary Kofstad, Division President**<br><br>Email Address:<br>**MKofstad@4signatureservice.com** | Date:<br>**1/29/2021**<br><br>Telephone Number:<br>**971-224-2033** |
| Legal Name of Applicant:<br><br>**Signature Hospice Pierce, LLC**<br><br>Address of Applicant<br><br>**909 S 336th St, Suite 100**<br>**Federal Way, WA 98003** | Provide a brief project description<br>☒ New Agency<br>☐ Expansion of Existing Agency<br>☐ Other: _____<br><br>Estimated capital expenditure: **$12,500**___ |
| Identify the county proposed to be served for this project. Note: Each hospice application must be submitted for one county only. If an applicant intends to obtain a Certificate of Need to serve more than one county, then an application must submitted for each county separately.<br><br>**Pierce County**_____ | |

# Table of Contents

## Applicant Description

Answers to the following questions will help the department fully understand the role of the applicant(s). Your answers in this section will provide context for the reviews under Financial Feasibility (WAC 246-310-220) and Structure and Process of Care (WAC 246-310-230).

1. Provide the legal name(s) and address(es)of the applicant(s).
   Note: The term "applicant" for this purpose includes any person or individual with a ten percent or greater financial interest in the partnership or corporation or other comparable legal entity as defined in WAC 246-310-010(6).

   The legal entity of this application is Signature Hospice Pierce, LLC.

   Applying the "applicant" definition above, the members with ten percent or greater ownership interest in the LLC are:

   Northwest Hospice, LLC dba Signature Healthcare at Home
   Signature Group, LLC
   Robert Thomas
   Signature Group Holdings, LLC
   K. Rickard Miller, Jr.
   Richard Dillon

   Signature Group, LLC owns 100% of Northwest Hospice, LLC which owns 100% of Signature Hospice Pierce, LLC. Signature Group, LLC is owned by Signature Group Holdings, LLC (85%) and Robert Thomas (15%). Signature Group Holdings, LLC is owned by K. Rickard Miller, Jr. (62.36%), Rick Dillon (31.18%) and Ron Odermott (6.46%).

   See attached **Exhibit 1** for the organizational structure, ownership percentages, and associated addresses of Signature Hospice Pierce, LLC.

   Historically, Signature Healthcare at Home was under the organizational structure of Avamere Group, LLC. As of 1/1/21, the ownership structure was changed to Signature Group, LLC as reflected in this application.

2. Identify the legal structure of the applicant (LLC, PLLC, etc.) and provide the Unified Business Identifier (UBI).

   Signature Hospice Pierce, LLC is registered with the Washington Secretary of State effective December 3, 2019 under UBI Number 604 544 521.
   See attached **Exhibit 2** for the Washington Secretary of State Certificate of Formation for Signature Hospice Pierce, LLC.
   Signature Hospice Pierce, LLC is a for profit, privately held limited liability company established in the State of Washington.

3. Provide the name, title, address, telephone number, and email address of the contact person for this application.

   Elyssa Ansberry
   Project Manager
   25117 SW Parkway Ave, Ste F
   Wilsonville, OR 97070
   971-224-2505
   eansberry@4signatureservice.com

   Kevin Kofstad
   Growth & Development Manager
   25117 SW Parkway Ave, Ste F
   Wilsonville, OR 97070
   406-671-2299
   kkofstad@4signatureservice.com

4. Provide the name, title, address, telephone number, and email address of the consultant authorized to speak on your behalf related to the screening of this application (if any).

   Not applicable as Signature Hospice Pierce, LLC does not have a consultant working on the application.

5. Provide an organizational chart that clearly identifies the business structure of the applicant(s).

   See attached **Exhibit 3** for the Signature Group organizational ownership structure and **Exhibit 1** for the Signature Hospice Pierce, LLC organizational ownership structure.

6. Identify all healthcare facilities and agencies owned, operated by, or managed by the applicant. This should include all facilities in Washington State as well as out-of-state facilities. The following identifying information should be included:
   - Facility and Agency Name(s)
   - Facility and Agency Location(s)
   - Facility and Agency License Number(s)
   - Facility and Agency CMS Certification Number(s)
   - Facility and Agency Accreditation Status

   Signature Hospice Pierce, LLC is a new entity established in the State of Washington to provide hospice service in Pierce County. The related entity ("applicant"), *Northwest Hospice, LLC dba Signature Healthcare at Home* currently operates 7 hospice locations in 3 states: 1 in Utah, 2 in Idaho, and 4 in Oregon.

Another related entity, *Avamere Home Health Care, LLC dba Signature Healthcare at Home*, currently operates 1 home health located in Bellingham, Washington in addition to 6 home health locations in Oregon, 1 home health location in Utah and 2 home health locations in Idaho for a total of 10.

*Prime Home Health, LLC dba Signature Healthcare at Home*, a related entity, currently operates 1 home health location in Federal Way, Washington.

*A-One Home Health Services, LLC dba Signature Healthcare at Home*, a related entity, currently operates 1 home health location in Bellevue, Washington.

See attached **Exhibit 4** for the *Signature Healthcare at Home* locations just listed and the requested information.

## Project Description

1. Provide the name and address of the existing agency, if applicable.

   This is not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not operate any hospice entities in the state of Washington.

2. If an existing Medicare and Medicaid certified hospice agency, explain if/how this proposed project will be operated in conjunction with the existing agency.

   This is not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not operate any hospice entities in the state of Washington.

3. Provide the name and address of the proposed agency. If an address is not yet assigned, provide the county parcel number and the approximate timeline for assignment of the address.

   The proposed agency is Signature Hospice Pierce, LLC. The proposed agency will occupy the space at the address below:

   909 S 336th St, Suite 100
   Federal Way, WA 98003

   The above address is in King County and is the site of the existing Signature Healthcare at Home agency that services both Pierce and King counties. With Federal Way located near the Pierce county line, this location serves as a convenient physical location for the proposed hospice agency and the locations proximity to the planning area will ensure timeliness of services.
   Despite being located in King county, the existing Home Health Agency primarily serves and employees Pierce county residents and has established relationships with healthcare service providers throughout the planning area.

Co-locating with our existing Agency in Federal Way will promote efficiency and productivity by allowing for shared services, shared administrative support, and shared overhead.

4. Provide a detailed description of the proposed project.

Signature Hospice Pierce, LLC is proposing a Medicare / Medicaid certified hospice agency in Pierce County, Washington. This new agency will provide the same high level of care currently provided by all *affiliated agencies*. Signature Hospice Pierce will provide exceptional in-home care wherever the patient calls home. Our focus of exceptional care delivery will be accomplished via a team of experienced and specialty trained professionals. The interdisciplinary team's central focus and goals for care delivery during hospice care will center on a holistic and integrated approach to quality, dignity, and comfort of care through the end of life to support medical, physical, emotional, social, and spiritual needs of the patient and their family.
The high level of care Signature Hospice Pierce can provide to the community will assure all residents of Pierce county in need of hospice services have access and choice to compassionate end of life care.

5. Confirm that this agency will be available and accessible to the entire geography of the county proposed to be served.

The proposed agency will be available and accessible to the entire county population of Pierce, Washington.

6. With the understanding that the review of a Certificate of Need application typically takes at least six to nine months, provide an estimated timeline for project implementation, below:

Table 1. Signature Hospice Pierce Project Timeline

| **Event** | **Anticipated Month/Year** |
|---|---|
| CN Approval | 09/2021 |
| Design Complete (if applicable) | NA |
| Construction Commenced (if applicable) | NA |
| Construction Completed (if applicable) | NA |
| Agency Prepared for Survey | 11/2021 |
| Agency Providing Medicare and Medicaid hospice services in the proposed county. | 01/2022 |

7. Identify the hospice services to be provided by this agency by checking all applicable boxes below. For hospice agencies, at least two of the services identified below must be provided.

Table 2. Services to be Provided by Signature Hospice Pierce, LLC

| | |
|---|---|
| X Skilled Nursing | X Durable Medical Equipment |
| X Home Health Aide | IV Services |
| X Physical Therapy | X Nutritional Counseling |
| X Occupational Therapy | X Bereavement Counseling |
| X Speech Therapy | X Symptom and Pain Management |
| Respiratory Therapy | X Pharmacy Services |
| X Medical Social Services | X Respite Care |
| X Palliative Care | X Spiritual Counseling |
| Other (please describe) | |

8. If this application proposes expanding an existing hospice agency, provide the county(ies) already served by the applicant and identify whether Medicare and Medicaid services are provided in the existing county(ies).

   This is not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not currently operate any hospice entities in the state of Washington.

9. If this application proposes expanding the service area of an existing hospice agency, clarify if the proposed services identified above are consistent with the existing services provided by the agency in other planning areas.

   This is not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not currently operate any hospice entities in the state of Washington.

10. Provide a general description of the types of patients to be served by the agency at project completion (e.g. age range, diagnoses, special populations, etc).

    Signature Hospice Pierce, LLC plans to serve any patient that needs hospice services regardless of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

11. Provide a copy of the letter of intent that was already submitted according to WAC 246-310-080 and WAC 246-310-290(3).

    See attached **Exhibit 5** for a copy of the Letter of Intent that was submitted.

12. Confirm that the agency will be licensed and certified by Medicare and Medicaid. If this application proposes the expansion of an existing agency, provide the existing agency's license number and Medicare and Medicaid numbers.

    Signature Hospice Pierce, LLC will be licensed and certified by Medicare and Medicaid once the CON is secured. As we do not operate any current hospice agencies in the state of Washington, filling out the areas below is not applicable.

HIS.FS._____

Medicare #:_____

Medicaid #:_____

13. Identify whether this agency will seek accreditation. If yes, identify the accrediting body.

Signature Hospice Pierce, LLC will seek accreditation through the Accreditation Commission for Healthcare, or ACHC, if granted the certificate of need.

## Certificate of Need Review Criteria

3. **Need (WAC 246-310-210)**

WAC 246-310-210 provides general criteria for an applicant to demonstrate need for healthcare facilities or services in the planning area. WAC 246-310-290 provides specific criteria for hospice agency applications. Documentation provided in this section must demonstrate that the proposed agency will be needed, available, and accessible to the community it proposes to serve. Some of the questions below only apply to existing agencies proposing to expand. For any questions that are not applicable to your project, explain why.

1. For existing agencies, using the table below, provide the hospice agency's historical utilization broken down by county for the last three full calendar years. Add additional tables as needed.

This is not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not currently operate any hospice entities in the state of Washington.

2. Provide the projected utilization for the proposed agency for the first three full years of operation. For existing agencies, also provide the intervening years between historical and projected. Include all assumptions used to make these projections.

Table 3. Signature Hospice Pierce, LLC Projected Utilization

| **COUNTY** | 2022 | 2023 | 2024 |
|---|---|---|---|
| Total number of admissions | 99 | 153 | 215 |
| Total number of visits | 1,584 | 2,448 | 3,440 |
| Projected number of visits/patient | 16 | 16 | 16 |

To obtain the projection for total number of visits, we multiplied the projected number of visits per patient by the total number of admissions in each year.

Our assumption is that the current providers will grow their admissions by 15%, so that leaves an unmet need of approximately 331 for the year 2022. If the Department awards one Certificate of need, our projections are of 99 admissions in year one, which represents 30% of the unmet need.
Even if two CONs are issued, we still project that we would admit 99 patients in year one, leaving 70% for another agency to assist with.
As we grow in the following years, we project that the unmet need will continue to grow by approximately 155 per year for the county, based on the year over year data in the DOH Need Methodology. We are projecting the ability to handle 35% of this unmet need in 2023, increasing our admissions to 153. If we maintain the growth of 5%, we could absorb 40% of the unmet need in 2024, increasing admissions to 215.
To identify a projected number of visits per patient, we utilized our EMR, HomeCare HomeBase, analytics platform. We looked at the entire state of Oregon's hospice agencies and found that the average number of visits per patient over the course of 2020 was 16 visits. This takes into account all types of visits; aide, skilled, MSW, etc.
We do not have any existing hospice agencies in Washington, so utilizing the data from Oregon's hospice agencies was a logical way to obtain a projection for visits per patient. Oregon has a similar demographics and market size to what we expect to see in Washington.

3. Identify any factors in the planning area that could restrict patient access to hospice services.

In addition to the current established unmet need, wherein a patient's access to hospice may be restricted by a shortage or providers, the planning area is home to many black, indigenous, people of color (BIPOC) individuals and Veterans, both of whom have a historic disparity in accessing healthcare and/or are underrepresented as a percentage of hospice beneficiaries compared to their percentage of the population.

The United States Census Bureau's July 1, 2019 Population estimates for Pierce County shows the following demographic statistics for Pierce county:

| Race and Hispanic Origin | |
|---|---|
| White alone, percent | 74.3% |
| Black or African American alone, percent (a) | 7.7% |
| American Indian and Alaska Native alone, percent (a) | 1.8% |
| Asian alone, percent (a) | 7.1% |
| Native Hawaiian and Other Pacific Islander alone, percent (a) | 1.8% |
| Two or More Races, percent | 7.4% |
| Hispanic or Latino, percent (b) | 11.4% |
| White alone, not Hispanic or Latino, percent | 65.7% |
| **Population Characteristics** | |
| Veterans, 2015-2019 | 86,002 |
| Foreign born persons, percent, 2015-2019 | 9.8% |

*Source: US Census Bureau QuickFacts: Pierce County, Washington; United States*
*https://www.census.gov/quickfacts/table/AGE275210/53053*

Racial disparities in utilization of hospice and palliative care abound, with Black and Hispanic populations less likely to receive a referral than white patients according to recent data from the US Agency for Healthcare Research and Quality.[1]

Pierce county is home to the Puyallup Indian Reservation and the Puyallup Tribe of Indians, a federally recognized Coast Salish tribe with greater than 5,000 enrolled members. In their October 2019 Indian Health Disparities report, the Indian Health Service addresses disparities in the health status of Native Americans stating:

> The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.
> Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011).[2]

Pierce county is home to Washington's second largest Veteran community, second only to neighboring King county. In addition to the Census Bureau estimates, the US Department of Veteran Affairs estimates the 2021 Veteran population of Pierce county to be greater than 90,000 individuals.[3]

[1] 2019 National Healthcare Quality and Disparities Report: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

[2] Indian Health Disparities. (2019, October). Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

[3] Veterans Affairs: https://www.va.gov/vetdata/veteran_population.asp

Veteran hospice utilization has increased since the Department of Veterans Affair's 2009 launch of the Comprehensive End-of-Life Care (CELC) Initiative, which intended to improve the quality of end-of-life care amongst Veterans through increased hospice enrollment. The VA's CELC data shed light on site of death, showing us that more Veterans are dying at home, compared to non-Veterans.[4] The COVID-19 pandemic has amplified the demand for integrated care delivery in the home setting.

4. Explain why this application is not considered an unnecessary duplication of services for the proposed planning area. Provide any documentation to support the response.

The need for hospice agencies in Pierce County has been determined by the 8 step Department of Health Need Methodology as published by the State of Washington in WAC246-310-290(8)(a-h). When this methodology is applied to Pierce County for the next upcoming year, 2022, it shows a need of 1.91 additional hospice agencies.
The Certificate of Need methodology and how this need was obtained is outlined below, utilizing the most recently published version of WAC 246-310-290 from October 2020. **See Exhibit 6** for full 2020- 2022 Hospice Need Methodology from the Department of Health.

Step 1.

Calculate the following two statewide predicted hospice use rates using the department of health survey and vital statistic data:
WAC 246-310-290(8)(a)(I) the percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty-five and over by the average number of past three years statewide total deaths age sixty-five and over.
WAC 246-310-290(8)(a)(ii) the percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total deaths under sixty-five.

[4] Miller, S., BE, K., JM, T., Al., E., T, E., KA, F., . . . A, K. (2017, July 01). Increasing Veterans' Hospice Use: The Veterans Health Administration's Focus On Improving End-Of-Life Care: Health Affairs Journal. Retrieved January 25, 2021, from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0173

Table 4.

| Statewide Hospice Admission and Deaths by Age Group and Year | | | |
|---|---|---|---|
| | 2017 | 2018 | 2019 |
| Hospice Admissions ages 0-64 | 3,757 | 4,114 | 3,699 |
| Hospice Admissions ages 65+ | 26,365 | 26,951 | 26,017 |
| Deaths ages 0-64 | 14,113 | 14,055 | 14,047 |
| Deaths ages 65+ | 42,918 | 42,773 | 44,159 |
| | | | |
| | | Use Rates | |
| | | 0-64 | 27.41% |
| | | 65+ | 60.50% |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 2.

WAC246-310-290(8)(b) calculate the average number of total resident deaths over the last three years for each planning area by age cohort.

Table 5.

| Pierce County Deaths by Age Group and Year | | | | |
|---|---|---|---|---|
| | 2017 | 2018 | 2019 | 2017-2019 Average Deaths |
| Deaths (0-64) | 1,936 | 1,964 | 1,911 | 1,937 |
| Deaths (65+ ) | 5,019 | 4,926 | 5,002 | 4,982 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 3.

WAC246-310-290(8)(c) multiply each hospice use rate determined in step 1 by the planning areas average total resident deaths determined in step 2, separated by age cohort.

Table 6.

| Pierce County Average Deaths and Projected Hospice Patients, by Age Group | | | |
|---|---|---|---|
| | 2017-2019 Average Deaths | Use Rates | Projected Hospice Patients |
| Deaths (0-64) | 1,937 | 27.38% | 531 |
| Deaths (65+ ) | 4,982 | 61.04% | 3,015 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 4.

WAC246-310-290(8)(d) Using the projected patients calculated in step 3, calculate a use rate by dividing the projected patients by the three-year historical average populating by

county. Using this rate to determine the potential volume of hospice use by the projected population by age cohort using the Office of Financial Management (OFM) data.

Table 7.

| Pierce County Projected Population and Potential Hospice Volume for 2020-2022 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Projected Patients | 2017-2019 Avg Population | 2020 Projected Population | 2021 Projected Population | 2022 Projected Population | 2020 Potential Volume | 2021 Potential Volume | 2022 Potential Volume |
| Ages 0-64 | 531 | 747,538 | 765,139 | 769,918 | 774,696 | 543 | 547 | 550 |
| Ages 65+ | 3,015 | 125,262 | 136,114 | 142,422 | 148,729 | 3,277 | 3,429 | 3,580 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 5.

WAC246-310-290(8)(e) Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in step 4 to determine the number of projected admissions beyond the planning area capacity.

According to the data collected by the Certificate of Need Program, the current capacity of the agencies currently operating in Pierce County is 3,740. By subtracting the current capacity from the potential volume of each year's data, we are left with the unmet admits for the next three years.

Table 8.

| Pierce County Potential Hospice Volume by Unmet Hospice Admits, 2020-2022 | | | | | | |
|---|---|---|---|---|---|---|
| 2020 Potential Volume | 2021 Potential Volume | 2022 Potential Volume | Current Capacity | 2020 Admits (Unmet) | 2021 Admits (Unmet) | 2022 Admits (Unmet) |
| 3,820 | 3,975 | 4,131 | 3,740 | 80 | 236 | 391 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 6.

WAC246-310-290(8)(f) Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years (2020-2022).

Assuming the Statewide ALOS of 62.66, we will multiply that number by the projected unmet admits, obtaining the projected unmet patient days of upcoming years.

Table 9.

| Pierce County Unmet Hospice Admits to find Unmet patient days, 2020-2022 | | | | | |
|---|---|---|---|---|---|
| 2020 Admits (Unmet) | 2021 Admits (Unmet) | 2022 Admits (Unmet) | 2020 Patient Days (Unmet) | 2021 Patient Days (Unmet) | 2022 Patient Days (Unmet) |
| 80 | 236 | 391 | 5,039 | 14,766 | 24,493 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 7.

WAC246-310-290(8)(g) Divide the unmet patient days from step 6 by 365 to determine the unmet need ADC (Average Daily Census)

Table 10.

| Pierce County Unmet Patient days & Unmet ADC, 2020-2022 | | | | | |
|---|---|---|---|---|---|
| 2020 Patient Days (Unmet) | 2021 Patient Days (Unmet) | 2022 Patient Days (Unmet) | 2020 ADC (Unmet) | 2021 ADC (Unmet) | 2022 ADC (Unmet) |
| 5,039 | 14,766 | 24,493 | 14 | 40 | 67 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Step 8.

WAC246-310-290(8)(h) Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of 35.

We will apply a logical reasoning method to the Unmet ADC to determine if the county has a need greater than 1. To do this, we divide the Unmet ADC in 2022 by 35, the resulting number is the number of agencies needed in that county, which is 1.91 agencies needed in Pierce County.

Table 11.

| Pierce County Numeric Need | |
|---|---|
| 2022 ADC (Unmet) | Number of Agencies needed in 2021 |
| 67 | 1.91 |

*Source: DOH 2020-2021 Hospice Need Methodology*

Since the state shows an unmet need of 1.91 agencies, this project would not be an unnecessary duplication of services in Pierce County.

5. Confirm the proposed agency will be available and accessible to the entire planning area.

The proposed agency, Signature Hospice Pierce, LLC will be available and accessible for the entire Pierce County.

6. Identify how this project will be available and accessible to under-served groups.

Signature Hospice Pierce, LLC will acquire Medicare & Medicaid certification, and is committed to charity care. Whether a private residence, Assisted Living Facility, Adult Foster Home, Nursing Home, apartment, or homeless shelter, Signature Hospice Pierce, LLC will provide care wherever the patient calls home. Once a referral for hospice is received, the intake process is started to evaluate for eligibility and to begin hospice care if patient is deemed terminally ill and elects to establish the benefit. Signature Hospice Pierce, LLC and all related entities offer care without regard to race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, place of national origin, income level, or other underserved groups. Every referral is processed, and our admissions and charity policy outline our full intent to

service every patient and family in need of hospice care, provided the requirements for Hospice eligibility are met.

Signature Hospice Pierce will provide cultural sensitivity training and education to ensure culturally competent care delivery to the diverse community that exists within the planning area. Signature Hospice Pierce will build community partnerships with trusted BIPOC and Veteran leaders aimed at fostering trust with the underserved communities they represent. Signature Hospice Pierce's community engagement strategy includes identifying champions within these communities to address barriers to hospice care such as public perception, language barriers, and culturally based apprehension regarding the cessation of curative treatment are among the reasons.

Signature Hospice Pierce strives to foster a workplace environment of purposeful inclusion and is committed to building a diverse workforce. Having staff with the ability to speak the language of their patients, and/or understand the cultural nuances of their patients' end-of-life choices, will improve care quality and patient and family satisfaction.

Signature's existing Home Health Agency in the planning area has an established relationship with the Veterans Administration Puget Sound Healthcare System and regularly provides Home Health services to Veterans in the planning area. We intend to leverage our existing relationship with the Community Health Nurse Coordinators to provide integrated care to hospice eligible Veterans.

Signature Hospice Pierce, LLC will become a hospice partner in NHPCO's We Honor Veterans program upon approval of our application, affirming our commitment to providing culturally competent, integrated care to Veterans at the end-of life. This partnership will provide educational tools and resources to promote Veteran-centric educational activities, increase organizational capacity to serve Veterans, support development of strategic partnerships, and increase access and improve quality.

7. Provide a copy of the following policies:
   - Admissions policy
     - See attached **Exhibit 7** for the Hospice 4-021 Admission Criteria and Process and for the Hospice 4-096 Intake Process Policy.
   - Charity care or financial assistance policy
     - See attached **Exhibit 8** for Hospice 3-007 Charity Care, plus its two appendixes: HO 3-007A. Sliding Fee Scale and HO 3-007B. Discount Application
   - Patient Rights and Responsibilities policy
     - See attached **Exhibit 9** for the Hospice 2-002 Patient Bill of Rights.

- Non-discrimination policy
  - See attached **Exhibit 10** for Hospice 2-037 Non Discrimination Policy and Grievance Process

- Any other policies directly related with patient access (example, involuntary discharge)
  - See attached **Exhibit 11** for Hospice 4-075 Discharge from Hospice Program policy and Hospice 2-001 Availability of Services policy.

8. If there is not sufficient numeric need to support approval of this project, provide documentation supporting the project's applicability under WAC 246-310-290(12). This section allows the department to approve a hospice agency in a planning area absent numeric need if it meets the following review criteria:
   - All applicable review criteria and standards with the exception of numeric need have been met;
   - The applicant commits to serving Medicare and Medicaid patients; and
   - A specific population is underserved; or
   - The population of the county is low enough that the methodology has not projected need in five years, and the population of the county is not sufficient to meet an ADC of thirty-five.

     Note: The department has sole discretion to grant or deny application(s) submitted under this subsection.

   Not applicable as Pierce county has a numeric need of 1.91 additional hospice agencies.

## B. Financial Feasibility (WAC 246-310-220)

Financial feasibility of a hospice project is based on the criteria in WAC 246-310-220.

1. Provide documentation that demonstrates the immediate and long-range capital and operating costs of the project can be met. This should include but is not limited to:
   - Utilization projections. These should be consistent with the projections provided under the Need section. Include all assumptions.
   - Pro Forma revenue and expense projections for at least the first three full calendar years of operation. Include all assumptions.
   - Pro Forma balance sheet for the current year and at least the first three full calendar years of operation. Include all assumptions.
   - For existing agencies proposing addition of another county, provide historical revenue and expense statements, including the current year. Ensure these are in the same format as the projections. For incomplete years, identify whether the data is annualized.

See attached **Exhibit 12** for the 3-year projections of Signature Hospice Pierce, LLC. This includes the P&L, Balance Sheet, Cash Flow, Staffing, and Assumptions for the years 2022-2024.

**Exhibit 13** shows the Washington Hospice Rates by County.

Existing Agency Financials - Since this is not an existing agency, no historical data was supplied.

2. Provide the following agreements/contracts:
    - Management agreement.
    - Operating agreement
    - Medical director agreement
    - Joint Venture agreement

    Note, all agreements above must be valid through at least the first three full years following completion or have a clause with automatic renewals. Any agreements in draft form must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

Management agreement – NA.
Signature Hospice Pierce, LLC will be operated and managed within the Signature Company.

Operating agreement – NA.
Signature Hospice Pierce, LLC will be operated and managed within the Signature Company.

Medical Director Agreement
Signature Hospice Pierce, LLC will engage in a Medical Director agreement with Swensen Medical Group and specifically with Dr.Floyd Sekeramayi upon Certificate of Need approval.
Since the Medical Director Agreement is a draft, a letter has been included that states the understanding of both parties of the conditions of execution, pending approval of the Certificate of Need. Should Signature Hospice Pierce not be awarded the CON, the contract will become null and void.

The letter and draft Medical Director agreement are attached in **Exhibit 14.**

Joint Venture agreement – NA
Signature Hospice Pierce, LLC will be operated and managed within the Signature Company.

3. Provide documentation of site control. This could include either a deed to the site or a lease agreement for the site.

   If this is an existing hospice agency and the proposed services would be provided from an existing main or branch office, provide a copy of the deed or lease agreement for the site. If a lease agreement is provided, the agreement must extend through at least the projection year. Provide any amendments, addendums, or substitute agreements to be created as a result of this project to demonstrate site control.

   If this is a new hospice agency at a new site, documentation of site control includes one of the following:
   a. An executed purchase agreement or deed for the site.
   b. A draft purchase agreement for the site. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.
   c. An executed lease agreement for at least three years with options to renew for not less than a total of two years.
   d. A draft lease agreement. For Certificate of Need purposes, draft agreements are acceptable if the draft identifies all entities entering into the agreement, outlines all roles and responsibilities of the entities, identifies all costs associated with the agreement, includes all exhibits referenced in the agreement. The draft agreement must include a document signed by both entities committing to execute the agreement as submitted following CN approval.

   The current lease expires on February 29, 2024 with a 3-year option to extend through February 28, 2027. All entities listed in the agreement and amendments are under the related entities as listed in **Exhibit 3**.
   This lease, the amendment, and a letter from the landlord allowing Signature Hospice Pierce, LLC occupancy if awarded the Certificate are attached in **Exhibit 15**.

4. Complete the table on the following page with the estimated capital expenditure associated with this project. Capital expenditure is defined under WAC 246-310-010(10). If you have other line items not listed in the table, include the definition of the line item. Include all assumptions used to create the capital expenditure estimate.

Table 12. Signature Hospice Pierce Capital Expenditure

| Item | Cost |
|---|---|
| a. Land Purchase | $ |
| b. Utilities to Lot Line | $ |
| c. Land Improvements | $ |
| d. Building Purchase | $ |
| e. Residual Value of Replaced Facility | $ |
| f. Building Construction | $ |
| g. Fixed Equipment (not already included in the construction contract) | $ |
| h. Movable Equipment | $12,500 |
| i. Architect and Engineering Fees | $ |
| j. Consulting Fees | $ |
| k. Site Preparation | $ |
| l. Supervision and Inspection of Site | $ |
| m. Any Costs Associated with Securing the Sources of Financing (include interim interest during construction) | |
| 1. Land | $ |
| 2. Building | $ |
| 3. Equipment | $ |
| 4. Other | $ |
| n. Washington Sales Tax | $ |
| **Total Estimated Capital Expenditure** | **$12,500** |

There is no construction for this project. We will be utilizing current home health office space.
Equipment expenditures are broken out in Table 13.
These items are reflected in the 'Capital Expenditure" line item in the P&L:

Table 13. Signature Hospice Pierce, LLC Capital Expenditure

| Capital Expenditure | Cost |
|---|---|
| Furniture | $2,800 |
| Phones (Hardware / setup) | $500 |
| IT – Computers, monitor, docks, equipment | $3,000 |
| Printer / Copier + Deliver | $3,000 |
| Tablets/Phones ($199 / tablet) | $1,200 |
| Miscellaneous (signage) | $2,000 |
| **TOTAL** | **$12,500** |

5. Identify the entity responsible for the estimated capital costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

The applicant, Northwest Hospice, LLC, will provide 100% of the capital for the equipment acquisitions listed in Table 13.

6. Identify the amount of start-up costs expected to be needed for this project. Include any assumptions that went into determining the start-up costs. Start-up costs should include any non-capital expenditure expenses incurred prior to the facility opening or initiating the proposed service. If no start-up costs are expected, explain why.

Non-capital expenditures in Table 14 include the licenses and fees and the CON application fee. Licenses and Fees is a line item in the P&L and includes the cost of the initial state license, ACHC accreditation, CMS 855A enrollment fee, and the initial CLIA license.

Table 14. Signature Hospice Pierce, LLC Non-Capital Expenditures

| **Add'l Non-Capital Expenditures** | **Cost** |
|---|---|
| Licenses & Fees | $13,062 |
| CON Application Fee | $21,968 |
| **TOTAL** | **$35,030** |

**Total of the capital and non-capital expenditure costs is $47,530.**

Our first-year projections in the Proforma take into consideration the startup costs listed above. They include assumptions around hiring and growth, which is one of the reasons why staffing and salaries are not included in either start up table above. The first couple months after the CON is awarded, we will begin to recruit, hire, and onboard an Administrator. It will take several months to find and hire and train an Administrator. However, while that is occurring, the we will rely on shared staff with the Home Health operation that we will share space with. Some of current home health staff, including the Administrator and some the nursing staff, will take over the duties related to the start up. They will have capacity and are aware of this. Therefore, we anticipate the salary for the Admin would not start until 2022. We have accounted for growth in the following years. This is done to reduce startup costs and utilize the resources we already have.
As we continue to grow during the first year, and subsequent years, we will continue to hire staff that are hospice specific.

We would not include home office salaries in the startup costs because it is part of their current roles and salaries to complete the licensing, set up, and general project management of startups and acquisitions. The initial labor costs related to licensing, set up and general management of startups and acquisition is incurred by Signature's Home Office. It would not be until the first year, 2022, when Signature Hospice Pierce starts treating patients and therefore generating revenue, that we would account for Home

Office Allocations, as projected on the P&L. This line item is a calculated as a percentage of revenue and therefore increases as the Hospice agency grows over the years.

Signature Hospice Pierce, LLC will be sharing an office space with the current Home Health agency in Federal Way. Since we would be sharing existing infrastructure at the office such as phones and printers, we have decreased our startup costs compared to if we were renting a whole new space.

7. Identify the entity responsible for the estimated start-up costs identified above. If more than one entity is responsible, provide breakdown of percentages and amounts for each.

Northwest Hospice, LLC is able to provide 100% of the estimated startup costs for Signature Hospice Pierce, LLC.
The included bank letter [Exhibit 16] shows funds available to be used by Northwest Hospice, LLC to start up Signature Hospice Pierce, LLC.

8. Explain how the project would or would not impact costs and charges for healthcare services in the planning area.

An additional hospice provider in the planning area will result in a decrease in both cost and charges for healthcare services in the planning area by improving rehospitalization, hospitalization, and ER utilization rates for vulnerable patients at the end of their life.

The table below is from Trella Health, an innovative company under CMS's Virtual Research Data Center Program. Trella analyzes more than 1.2 billion Medicare Part A and B claims annually. Signature Healthcare at Home is a customer of Trella Health and we rely on their data to build higher-performing care networks, serve more patients, improve outcomes, and reduce the cost of care.

The table shows the average number of Inpatient, ER to Inpatient, ER, and Observation visits per patient to Multicare Allenmore for patients in the last 6 months of their life, based on Medicare claims. It distinguishes between early hospice (individuals who elected the hospice benefit greater than or equal to 30 days prior to their death); late hospice (individuals who elected the hospice benefit less than 30 days prior to their death; and no hospice (individuals who died with no hospice). The table shows that, regardless of visit type, the average visits per patient are significantly higher for the no hospice cohort, and lowest for the early hospice cohort, thus clearly illustrating the correlation between hospice and decreased utilization costs and charges.

Table 15. Hospice Timing vs Visits for Multicare Allenmore vs the state of Washington

| Hospice Timing | Patient Count | AVERAGE INPATIENT VISITS | | AVERAGE ER-TO-INPATIENT VISITS | | AVERAGE ER VISITS | | AVERAGE OBSERVATION VISITS | |
|---|---|---|---|---|---|---|---|---|---|
| | | This Facility | State | This Facility | State | This Facility | State | This Facility | State |
| Early Hospice | 66 | 0.03 | 0.01 | 0.11 | 0.06 | 0.11 | 0.03 | 0.00 | 0.00 |
| Late Hospice | 215 | 0.06 | 0.12 | 0.66 | 0.65 | 0.21 | 0.21 | 0.02 | 0.03 |
| No Hospice | 444 | 0.17 | 0.21 | 0.84 | 0.71 | 0.28 | 0.26 | 0.03 | 0.03 |
| **Total** | **725** | **0.13** | **0.16** | **0.72** | **0.62** | **0.24** | **0.21** | **0.02** | **0.03** |

*Source: Trella Health*

Medicare claims data in Trella Health also show us that the planning area's 3 largest hospitals, Multicare Good Samaritan, Multicare Allenmore, and CHI St Joseph's have 30 day readmission rates of 15.85%, 14.53%, and 14.24%, respectively, all of which are higher than the state average of 13.29%.

Table 16. Pierce County Hospital Compare Data

| Facility Name | County / ZIP | City | Facility Type | Claim Type | Star Rating | Annual Patient Count (FFS) | Annual Patient Count (MA) | Hospice Patients | Hospice ALOS (Days) | Readmit OR Hospitalization + 30 Days Rate | Patient Risk Score | Risk Category | Mortalities (6 Month) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| TACOMA GENERAL ALLENMORE | PIERCE 98405 | TACOMA | General Acute Care Hospital | INP | 3. | 4,284 | 1,855 | 188 | 28 | 14.5% | 2.17 | Medium | 725 |
| MULTICARE GOOD SAMARITAN HOSPI | PIERCE 98372 | PUYALLUP | General Acute Care Hospital | INP | 3. | 4,271 | 1,797 | 269 | 31 | 15.8% | 2.32 | Medium | 833 |
| ST JOSEPH MEDICAL CENTER | PIERCE 98405 | TACOMA | General Acute Care Hospital | INP | 3. | 3,552 | 2,480 | 227 | 20 | 14.2% | 2.19 | Medium | 712 |

*Source: Trella Health*

These figures represent the percentage of patients readmitted into any hospital within 30 days of their discharge from the listed inpatient facility during the two-year reporting period.

The table below from *The American Journal of Hospice & Palliative Care* further supports our position that utilization of hospice results in lower healthcare costs. The table compares the cost of patients treated in acute hospitals during the last 180 days of life to the per diem cost of hospice. The article states "With 25% of all Medicare beneficiaries dying in inpatient hospitals, the savings from increased hospice use could be considerable". [5]

[5] Ian Duncan, T. (2019, March 18). Medicare Cost at End of Life - Ian Duncan, Tamim Ahmed, Henry Dove, Terri L. Maxwell, 2019. Retrieved from https://journals.sagepub.com/doi/10.1177/1049909119836204

Table 17.

Average Cost per Day for Patients Dying in Hospital Compared with Cost per Day in Hospice.

| Days Prior to Death | Hospital Cost Per day | Hospice Cost Per day |
|---|---|---|
| 1-3 | $5983 | $230.74 |
| 4-7 | 638 | 230.74 |
| 8-20 | 493 | 190.55 |
| 21-40 | 349 | 190.55 |
| 41-60 | 267 | 190.55 |
| 60-90 | 220 | 190.55 |
| 90-130 | 184 | 190.55 |
| 130-180 | 156 | 190.55 |

*Source: Ian Duncan, T. (2019, March 18). Medicare Cost at End of Life - Ian Duncan, Tamim Ahmed, Henry Dove, Terri L. Maxwell, 2019. Retrieved from https://journals.sagepub.com/doi/10.1177/1049909119836204*

Based on the information from this table, the cost savings is undeniable. An additional, culturally competent, hospice provider in the planning area would undoubtedly improve those rates by providing comprehensive end of life care to the growing number of individuals who want to avoid hospitals and die in their homes. Signature Hospice Pierce would be such a provider to meet that need.

9. Explain how the costs of the project, including any construction costs, will not result in an unreasonable impact on the costs and charges for health services in the planning area.

This project is being funded from cash on hand from Northwest Hospice, LLC and will not impact costs or charges for health services.

10. Provide the projected payer mix by revenue and by patients by county as well as for the entire agency using the example table below. Medicare and Medicaid managed care plans should be included within the Medicare and Medicaid lines, respectively. If “other” is a category, define what is included in “other.”

Table 18. Signature Hospice Pierce, LLC Payer Mix

| Payer Mix | Percentage of Gross Revenue | Percentage by Patient |
|---|---|---|
| Medicare | 95% | 94.05% |
| Medicaid | 4% | 3.96% |
| Other Payers (list in individual lines) | 1% | 1.99% |
| Total | 100% | 100% |

Other payors are defined as Commercial payers, which will occupy 1% of the percentage by gross revenue and 1.99% percentage by patient.
Our P&L shows Gross Revenue as 'Total Revenue.'

11. If this project proposes the addition of a county for an existing agency, provide the historical payer mix by revenue and patients for the existing agency. The table format should be consistent with the table shown above.

    This is not applicable as Signature Hospice/ Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

12. Provide a listing of equipment proposed for this project. The list should include estimated costs for the equipment. If no equipment is required, explain.

Table 19. Signature Hospice Pierce, LLC Equipment

| **Equipment** | **Cost** |
|---|---|
| Furniture | $2,800 |
| Phones (Hardware / setup) | $500 |
| IT – Computers, monitor, docks, equipment | $3,000 |
| Printer / Copier + Delivery | $3,000 |
| Tablets/Phones ($199 / tablet) | $1,200 |
| **TOTAL** | **$10,500** |

13. Identify the source(s) of financing (loan, grant, gifts, etc.) and provide supporting documentation from the source. Examples of supporting documentation include: a letter from the applicant's CFO committing to pay for the project or draft terms from a financial institution.

    See attached letter from the CFO providing support for financing this project in **Exhibit 17.**
    As specified in the letter from the CFO, we have also included a letter from the bank which shows that funds are available to be used for this project. This letter from the bank is attached in **Exhibit 16**.

14. If this project will be debt financed through a financial institution, provide a repayment schedule showing interest and principal amount for each year over which the debt will be amortized.

    Not applicable as this project will be financed with cash on hand.

15. Provide the most recent audited financial statements for:
    - The applicant, and
    - Any parent entity responsible for financing the project.

    Historically, Signature Healthcare at Home and all related entities of Home Health and Hospice were under the ownership of Avamere Group, LLC. As of 1/1/21, Signature Healthcare at Home and all related entities are now under the parent company Signature Group, LLC. Because Signature recently came under new ownership, we do not have audited financials for the parent entity, Signature Group, LLC or for the applicant, Northwest Hospice, LLC. (Please reference **Exhibit 1** for the new ownership structure).

    In lieu of this, we have included a bank letter from Northwest Hospice, LLC which shows sufficient cash on hand to cover the capital and non-capital expenditure costs of the startup (**Exhibit 16**).

    In addition, we have attached a letter which shows the line of credit from the parent entity that we have available to be used for this project. This letter is available in **Exhibit 18.**

## C. Structure and Process (Quality) of Care (WAC 246-310-230)

Projects are evaluated based on the criteria in WAC 246-310-230 for staffing availability, relationships with other healthcare entities, relationships with ancillary and support services, and compliance with federal and state requirements. Some of the questions within this section have implications on financial feasibility under WAC 246-310-220.

1. Provide a table that shows FTEs [full time equivalents] by category for the county proposed in this application. All staff categories should be defined.

Table 20. Signature Hospice Pierce, LLC Staffing Matrix

| **Pierce Hospice** | | | | | |
|---|---|---|---|---|---|
| **Staffing Details** | | **FTE Count** | **FTE Count** | **FTE Count** |
| **HCHB's staff to patient ratio (based on ADC)** | | ***2022*** | ***2023*** | ***2024*** |
| | **$ Rate/hr** | | | |
| **Clinical** | | | | |
| Salaries - RN | 45 | 1.75 | 3.00 | 3.00 |
| Salaries - LPN & LVN | 32 | 0.25 | 1.00 | 1.00 |
| Salaries - HHA (CCNA's) | 22 | 1.00 | 3.00 | 3.00 |
| Salaries - Medical Director (Contracted) | 150 | 0.25 | 0.25 | 0.25 |
| Salaries - Spiritual Counseling | 30 | 1.00 | 1.00 | 1.00 |
| Salaries - Volunteer Coordinator | 30 | 0.25 | 0.25 | 0.25 |
| Salaries - Medical Social Worker (MSW) | 35 | 0.75 | 1.00 | 1.00 |
| | | | | |
| **Total Direct** | | **5.25** | **9.50** | **9.50** |
| | | | | |
| **Administrative** | | | | |
| Salaries - Administrator | 56 | 0.50 | 0.75 | 1.00 |
| Salaries - Business Office Manager | 33 | 1.00 | 1.00 | 1.00 |
| Salaries - Intake Coordinator/Scheduler | 24 | 1.00 | 1.00 | 1.00 |
| Salaries - Sales- Patient Service Rep | 34 | 0.50 | 1.00 | 1.50 |
| Salaries - Clinical Manager | 50 | 0.50 | 1.00 | 1.00 |
| | | | | |
| **Total Admin** | | **3.50** | **4.75** | **5.50** |
| | | | | |
| **Total** | | **8.75** | **14.25** | **15.00** |

*Exhibit 12 - Staffing Matrix*

2. If this application proposes the expansion of an **existing** agency into another county, provide an FTE table for the entire agency, including at least the most recent three full years of operation, the current year, and the first three full years of operation following project completion. There should be no gaps in years. All staff categories should be defined.

   Not applicable as Signature Hospice Pierce, LLC/Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

3. Provide the assumptions used to project the number and types of FTEs identified for this project.

   Signature Healthcare at Home currently utilizes HomeCare HomeBase (HCHB) as the Electronic Medical Record (EMR) for all affiliated Home Health and Hospice agencies. HomeCare HomeBase is an industry leading EMR for both Home Health and Hospice and provides its clients with a suggested staffing matrix based on Hospice average daily census. We used this matrix, as well as our experience operating hospice agencies in Oregon, Utah, and Idaho, to inform our FTE count for the planning area.
   The HCHB Staffing Matrix and Assumptions, are attached in **Exhibit 19**, and our comments are outlined below:

The RN FTE count was adjusted to 1.75 to account for the gradual census growth that will be realized in Signature Hospice Pierce's first year of operation. We anticipate adding a second RN FTE when our ADC is 10, at the close of the first quarter 2022.

Another change was made to the Volunteer Coordinator and Medical Social Worker. HCHB recommends that we have .25 volunteer coordinators and 1 MSW with the ADC for our first year. However, with the small census we would have in the first year, we would have one individual fulfill both roles as the Volunteer Coordinator and the MSW. We showed this by splitting the time between the 2 roles on the staffing matrix.

Although the matrix does not recommend a Clinical Field Staff Supervisor until the ADC is greater than 20, we added a .5 Clinical Manager FTE in 2022 to oversee and promote care quality and provide training and support to the interdisciplinary team.

We added the role of Administrator to our Office staff as our current agencies operate with an Administrator and a Business Office Manager. We took their recommendation for our BOM in the role that they call a "Branch Director."

The total Administrative FTE count is slightly higher than what is proposed in the matrix to allow for robust back office support, and increased education and training in our first years of operation.

4. Provide a detailed explanation of why the staffing for the agency is adequate for the number of patients and visits projected.

HomeCare HomeBase is an industry expert and their staffing matrix is tried and true. They recommend their agencies utilize the matrix in order to achieve the best results for a streamlined agency.
Signature is confident that our proposed staffing for the agency is adequate for the number of patients and visits projected. The staff to patient ratios are aligned with those in our affiliated hospice agencies and across the hospice industry.

See attached **Exhibit 19** for the HCHB Staffing Model

5. Provide the name and professional license number of the current or proposed medical director. If not already disclosed under 210(1) identify if the medical director is an employee or under contract.

Dr.Floyd Sekeramayi will be our contracted Medical Director should the Certificate of Need be approved.
His Professional license number is MD60300185 and a copy of his license is attached in **Exhibit 20.**

6. If the medical director is/will be an employee rather than under contract, provide the medical director's job description.

   While the Medical Director is contracted, we included a job description to be signed by the MD upon approval of the CON.

   Please see attached **Exhibit 21** for the Medical Director job description.

7. Identify key staff by name and professional license number, if known. (nurse manager, clinical director, etc.)

   We have identified the following staff from our Home Health agency to start the hospice project if we are awarded the CON.

   Table 21. Pierce County Key Staff

| **Role** | **Name** | **Prof License** |
|---|---|---|
| Administrator | Kristina Kizer | PT00009923 |
| Director of Prof Services/Clinical Manager | Latisha Newkirk | RN00125504 |

8. For existing agencies, provide names and professional license numbers for current credentialed staff.

   Not applicable because Signature Hospice Pierce, LLC/ Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

9. Describe your methods for staff recruitment and retention. If any barriers to staff recruitment exist in the planning area, provide a detailed description of your plan to staff this project.

   See attached **Exhibit 22** for details on recruitment methods and retention.

10. Identify your intended hours of operation and explain how patients will have access to services outside the intended hours of operation.

    Signature Hospice Pierce, LLC will offer a 24/7 clinical operation with business operating hours from 8am – 5pm Monday - Friday. Services that will be provided 24/7 include physician, nursing, pharmacy, and patient referrals. Other services will be available 24/7 as reasonable and necessary to meet the patient and family needs. Providing services outside of business operating hours will be accomplished through a combination of an experienced internal Hospice RN Triage Team and agency level staff to provide in-person patient visits as needed to ensure optimal symptom management, crisis care and emotional/spiritual support for the patient and family.

11. For **existing** agencies, clarify whether the applicant currently has a method for assessing customer satisfaction and quality improvement for the hospice agency.

    Not applicable because Signature Hospice Pierce, LLC / Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

12. For **existing** agencies, provide a listing of ancillary and support service vendors already in place.

    Not applicable because Signature Hospice Pierce, LLC / Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

13. Identify whether any of the existing ancillary or support agreements are expected to change as a result of this project.

    Not applicable because Signature Hospice Pierce, LLC / Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

14. For **new** agencies, provide a listing of ancillary and support services that will be established.

    Signature Hospice Pierce anticipates using many of the same support services as our Signature Home Health in Bellevue & Federal Way currently utilize. Upon Certificate of Need approval Signature Hospice Pierce will enter into new contracts with vendors to include pharmacy, inpatient, and respite care as well as pet, massage, dietary, art, and any other necessary therapies.

    We would enter into a contract or employ Physical/Occupational/Speech Therapy via an employee sharing agreement between the home health and hospice agencies.

    In addition to providing 13 months of bereavement services after death, we contract with Full Circle After Care to provide the bereaved with assistance in wrapping up estate issues and notifications. There is no cost to the family for this service as it is paid for by Signature. We have been providing this service in our other markets for several years and the feedback from those using this service is overwhelmingly positive.

    Lastly, Signature Hospice Pierce, LLC will utilize the Avamere Family of Companies for Legal, IT, HR, accounting, and revenue cycle support.

15. For **existing** agencies, provide a listing of healthcare facilities with which the hospice agency has working relationships.

    Not applicable because Signature Hospice Pierce, LLC / Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

16. Clarify whether any of the existing working relationships would change as a result of this project.

Not applicable because Signature Hospice Pierce, LLC / Northwest Hospice, LLC does not currently operate any hospice agencies in the state of Washington.

17. For a **new** agency, provide a listing of healthcare facilities with which the hospice agency would establish working relationships.

Signature Home Health has established, working relationships with the facilities listed below in the planning area. Signature Hospice Pierce plans to utilize these facilities, which includes but is not limited to, the following:

Pierce County
Franciscan Saint Anthony Hospital
Franciscan Saint Clare Hospital
CHI Franciscan Rainier Health Network
CHI St.Joseph Health
Multicare Good Samaritan Hospital
Multicare Tacoma General Hospital
Multicare Tacoma General- Allenmore
VA Medical Center
Internal Medicine Northwest
Franciscan St Joseph Hospital
Franciscan Saint Elizabeth Hospital
Concerta Health
University Place Care Center
Washington Soldier's Home
Lifecare Center of Puyallup
Rainier Rehabilitation
Regency at Puyallup
Madigan
Avamere Transitional
Avamere Heritage
Avamere Pacific Ridge
Alaska Gardens
Orchard Park
The Oaks
Tacoma Nursing and Rehab
Life Care Center South Hill
Linden Grove
Enumclaw Health and Rehab
Cottesmore of Life Care- Gig Harbor
Life Care Center of Port Orchard
Park Rose Care Center
Penrose Harbor at Heron's Key

Stafford Healthcare at Ridgemont
Stafford Healthcare- Bremerton
Tacoma Lutheran Home
Franke Tobey Jones Home

18. Identify whether any facility or practitioner associated with this application has a history of the actions listed below. If so, provide evidence that the proposed or existing facility can and will be operated in a manner that ensures safe and adequate care to the public and conforms to applicable federal and state requirements. WAC 246-310-230(3) and (5)
    a. A criminal conviction which is reasonably related to the applicant's competency to exercise responsibility for the ownership or operation of a hospice care agency; or
    b. A revocation of a license to operate a health care facility; or
    c. A revocation of a license to practice a health profession; or
    d. Decertification as a provider of services in the Medicare or Medicaid program because of failure to comply with applicable federal conditions of participation.

No facility or practitioner associated with this application have any history of criminal convictions, have been denied or had revoked a license to operate a health care facility or to practice a health care profession or have been decertified as a Medicare or Medicaid provider.

19. Provide a discussion explaining how the proposed project will promote continuity in the provision of health care services in the planning area, and not result in an unwarranted fragmentation of services. WAC 246-310-230

Signature Healthcare at Home is an existing Medicare certified provider of skilled Home Health care in Pierce county. The current landscape necessitates that Signature's home health clients who become hospice eligible must establish care with a new provider upon election of hospice. The ability to provide hospice care to former home health clients, to which the agency has an existing relationship, would improve the current fragmented care delivery model that exists.

As of January 2020, the Signature Home Health Agency that serves Pierce county has an average daily census of approximately 300 clients, with an average of 134 monthly discharges. More than half of these clients are between the ages of 65 and 84, and an additional 29% are 85 or older. Assuming 5% of clients discharging from home health are hospice eligible, (5% being a conservative estimate that would grow based on the home health agency's diagnostic mix and growing acuity), an average of 7 clients are currently discharging from Signature Healthcare at Home to another hospice provider in Pierce county. With a State assumed average hospice length of service of 62.66 days, this means that conservatively 84 decedents in Pierce county had to establish care with a new homecare provider in the last 2 months of their life.

Signature's existing Home Health Agency in Pierce has an average length of service of 54 days, during which the interdisciplinary group (IDG) is building rapport and trust and establishing a therapeutic relationship with the patient and family. While individual members of the patient's interdisciplinary care team may change if the patient ultimately has a need to move from home health to hospice, both the patient and the IDG will benefit from these two levels of care being provided by, ultimately, the same entity. The hospice IDG will have unparalleled access to the previous care team, surpassing the notion of a "warm handoff" and facilitating a smooth transition as the patient transitions from home health to hospice. This will reduce administrative burden and allow for expedited pain and symptom management.

20. Provide a discussion explaining how the proposed project will have an appropriate relationship to the service area's existing health care system as required in WAC 246-310-230.

As a Medicare certified Home Health agency since 1996, Signature Healthcare at Home has established relationships throughout Pierce county's existing health care system, averaging 5.37% of the Home Health Medicare market share over the last 4 quarters. (See **Exhibit 23** for the Trella Health Marketshare Data.)

MultiCare system treats the highest Medicare FFS volume in the planning area, followed by CHI Franciscan. Signature's existing home health agency serves as an overflow resource to MultiCare when their affiliated home health agency cannot accommodate and/or is at capacity. Despite having their own affiliated home health provider, Signature's existing Home health agency has a 5.3% level of affiliation with Multicare Allenmore, and a 5.2% level of affiliation with Multicare Good Samaritan. We are confident that our hospice program will develop a similar overflow relationship with this critically important healthcare system in the planning area.

Signature's existing Home Health Agency is a member of CHI Franciscan's Rainer Health Network Accountable Care Organization and has a 6.7% level of affiliation with CHI's St Joseph Medical Center. We intend to extend our hospice services to this health care system, and relationship, as well.

Table 22.

Signature Health Care at Home Affilation in Pierce County

| Facility Name | Annual Patient Count | Level of Affiliation |
|---|---|---|
| Multicare Allenmore | 87 | 5.3% |
| Multicare Good Samaritan | 56 | 5.2% |
| CHI St. Joseph | 51 | 6.7% |

*Source: Trella Health*

21. The department will complete a quality-of-care analysis using publicly available information from CMS. If any facilities or agencies owned or operated by the applicant reflect a pattern of condition-level findings, provide applicable plans of correction identifying the facility's current compliance status.

Please see attached **Exhibit 24** for Northwest Hospice, LLC quality information and internal plans of correction.
**Exhibit 25** contains Avamere Home Health Care, LLC Home Health quality information and internal plans of correction.

Signature Healthcare at Home sold 4 agencies this year to the Pennant Group. Specifically, Avamere Home Health Care, LLC (the home health business line) sold the following agencies on July 1, 2020: Ogden UT (PTAN 46-7219) and Pocatello, Idaho which included branch offices in Preston and Idaho Falls (PTAN 13-7110)
Northwest Hospice, LLC (the hospice business line) sold the same locations on July 1,2020: Ogden, Utah (PTAN 46-1550) and Pocatello, Idaho which includes branch offices in Preston and Idaho Falls (PTAN 13-1552).
Any data associated with these agencies after this sell date would not be associated with our company.

22. If information provided in response to the question above shows a history of condition-level findings, provide clear, cogent, and convincing evidence that the applicant can and will operate the proposed project in a manner that ensures safe and adequate care, and conforms to applicable federal and state requirements.

There were no condition-level findings at any entities under the Signature Group Holdings, LLC (which includes Home Health and Hospice), therefore this question is not applicable.

**D. Cost Containment (WAC 246-310-240)**

Projects are evaluated based on the criteria in WAC 246-310-240 in order to identify the best available project for the planning area.

1. Identify all alternatives considered prior to submitting this project. At a minimum include a brief discussion of this project versus no project.

   We considered acquisition, merger, or start up as options to providing hospice services in Pierce County.
   Based on the Department of Health's identified unmet need for Pierce county, no project is not an option. The best way to fill the unmet need and provide quality hospice care is a start up by Signature Hospice Pierce, LLC.

   We will address the details of the alternative projects considered in the question below.

2. Provide a comparison of the project with alternatives rejected by the applicant. Include the rationale for considering this project to be superior to the rejected alternatives. Factors to consider can include, but are not limited to: patient access to healthcare services, capital cost, legal restrictions, staffing impacts, quality of care, and cost or operation efficiency.

   There are three options Signature considered to provide hospice services in Pierce County: acquisitions, merger, and start up.

   Currently, hospice acquisitions are very cost prohibitive, and we were not able to identify any hospice agencies for sale in the planning area.

   We did not actively pursue a merger as Signature is a privately held entity who strives for quality of care. Due to the complex and expensive nature of mergers, we can conversely conduct a startup for $12,500 as we will be operating out of our current Home Health agency.

   Signature Healthcare at Home chose to pursue a hospice agency in Pierce County based on unmet need, delays in care, and the negative impact these have on patients and families. Having an existing home health agency offers us the ability for scaling savings with current vendors in addition to sharing locations, efficiencies with administrative oversight and EMR optimization for system of care coordination. Due to the identified need for hospice services in Pierce County, the ability to share administrative support and services with our related entities, and the associated cost savings, Signature Hospice Pierce is well positioned for a start up in the planning

area. In our evaluation, a startup is the most cost-effective option to filling the unmet need of hospice care in Pierce county.

3. If the project involves construction, provide information that supports conformance with WAC 246-310-240(2):
    - The costs, scope, and methods of construction and energy conservation are reasonable; and
    - The project will not have an unreasonable impact on the costs and charges to the public of providing health services by other persons.

    Not applicable as the project does not involve any construction.

4. Identify any aspects of the project that will involve appropriate improvements or innovations in the financing and delivery of health services which foster cost containment, and which promote quality assurance and cost effectiveness.

    A growing majority of Americans report wanting to die in their home, and the COVID-19 infection risks associated with hospitalizations and nursing home stays has strengthened this already dramatic preference. Hospital and SNF avoidance/diversion is a national trend in our current pandemic era, as the healthcare consumer is increasingly driving care delivery into the home setting. Since its inception, the Medicare Hospice benefit has allowed for its beneficiaries to receive hospice services wherever they call home. Hospice providers' core competency is end-of-life care in the home setting, allowing hospice beneficiaries to avoid unnecessary hospitalizations and ER visits at the end of life by bringing individualized, integrated, culturally competent, holistic, and high-quality interdisciplinary care to their home.

    With patients, families, and facilities denying visits due to COVID-19 exposure risk, 2020 has brought unparalleled innovations from hospice agencies coast to coast to ensure their patients' care needs were being met safely, in the home. Within our Signature Healthcare at Home affiliated entities, we used remote patient monitoring, have conducted virtual telehealth video visits, and even "window" visits (where clinician and patient are on opposite sides of the glass) in order to meet our patients needs without compromising infection control. We have facilitated myriad opportunities for hospice patients to meaningfully engage with their loved ones without breaking isolation protocols or creating exposure risk. And, sadly, our team has acted as a proxy for our patients' family members who were unable to be physically present for their loved one's last embrace. These innovations in care delivery have allowed our patients to meet their end-of-life goals, while reducing costs and risks associated with hospitalizations.

Signature Healthcare at Home recognizes that access to timely and skilled hospice and palliative care is critical not only for quality outcomes, but also to decrease costs related to increased out of pocket expenses, unnecessary hospitalizations, increased ER visits and clinic visits. Signature Hospice Pierce will ensure timely and efficiently care can be delivered, and patients eligible and choosing the benefit of hospice will have the choice and access available at the time they need it.

**Hospice Agency Superiority**

In the event that two or more applications meet all applicable review criteria and there is not enough need projected for more than one approval, the department uses the criteria in WAC 246-310-290(11) to determine the superior proposal.

**Multiple Applications in One Year**

In the event you are preparing more than one application for different planning areas under the same parent company – regardless of how the proposed agencies will be operated – the department will require additional financial information to assess conformance with WAC 246-310-220. The type of financial information required from the department will depend on how you propose to operate the proposed projects. Related to this, answer the following questions:

1. Is the applicant (defined under WAC 246-310-010(6)) submitting any other hospice applications under either of this year's concurrent review cycles? This could include the same parent corporation or group of individuals submitting under separate LLCs under their common ownership.

   If the answer to this question is no, there is no need to complete further questions under this section.

   No, Signature Hospice Pierce and its related entities (Northwest Hospice, LLC, Signature Group, LLC & Signature Group Holdings, LLC) will not be applying for more than one (1) county in the 2020-2021 Concurrent Review Cycle.

2. If the answer to the previous question is yes, clarify:
   - Are these applications being submitted under separate companies owned by the same applicant(s); or
   - Are these applications being submitted under a single company/applicant?
   - Will they be operated under some other structure? Describe in detail.

   This is not applicable as Northwest Hospice, LLC/Signature Group, LLC is only applying for the Hospice Certificate of Need in Pierce county in the 2020-2021 Concurrent Review Cycle.

3. Under the financial feasibility section, you should have provided a pro forma balance sheet showing the financial position of this project in the first three full calendar years of operation. Provide pro forma balance sheets for the **applicant,** assuming approval of this project showing the first three full calendar years of operation. In addition, provide a pro forma balance sheet for the **applicant** assuming approval of **all** proposed projects in this year's review cycles showing the first three full calendar years of operation.

   This is not applicable as Northwest Hospice, LLC/Signature Group, LLC is only applying for the Hospice Certificate of Need in Pierce county in the 2020-2021 Concurrent Review Cycle.

4. In the event that the department can approve more than one county for the same applicant, further pro forma revenue and expense statements **may** be required.
   - If your applications propose operating multiple counties under the same license, provide combined pro forma revenue and expense statements showing the first three full calendar years of operation assuming approval of all proposed counties.
   - If your applications propose operating multiple counties under separate licenses, there is no need to provide further pro forma revenue and expense statements.

This is not applicable as Northwest Hospice, LLC/Signature Group, LLC is only applying for the Hospice Certificate of Need in Pierce county in the 2020-2021 Concurrent Review Cycle.

# Certificate of Need Program Revised Code of Washington (RCW) and Washington Administrative Code (WAC)

Certificate of Need Program laws RCW 70.38

Certificate of Need Program rules WAC 246-310

**Commonly Referenced Rules for Hospice Projects:**

| WAC Reference | Title/Topic |
|---|---|
| 246-310-010 | Certificate of Need Definitions |
| 246-310-200 | Bases for findings and action on applications |
| 246-310-210 | Determination of Need |
| 246-310-220 | Determination of Financial Feasibility |
| 246-310-230 | Criteria for Structure and Process of Care |
| 246-310-240 | Determination of Cost Containment |
| 246-310-290 | Hospice services—Standards and need forecasting method. |

**Certificate of Need Contact Information:**
Certificate of Need Program Web Page
Phone: (360) 236-2955
Email: FSLCON@doh.wa.gov

**Licensing Resources:**
In-Home Services Agencies Laws, RCW 70.127
In-Home Services Agencies Rules, WAC 246-335
Hospice Agencies Program Web Page

## EXHIBITS:

## EXHIBIT 1: Signature Hospice Pierce, LLC Organizational Chart

**SIGNATURE HOSPICE PIERCE, LLC**
**ORGANIZATIONAL CHART**

Signature Hospice Pierce, LLC
Northwest Hospice, LLC; 25117 SW Parkway, Suite F, Wilsonville, OR 97070; 20-3033510

Signature Group, LLC; 25117 SW Parkway, Suite F, Wilsonville, OR 97070; 86-1221897

Signature Group Holdings, LLC; 25117 SW Parkway, Suite F, Wilsonville, OR 97070; 86-1258298
Robert Thomas; 17725 NW Gilbert Lane, Portland, OR 97229; 168-56-7321; 02/11/1964

Karl R. Miller, Jr.; 1850 North Shore Road, Lake Oswego, OR 97034; 544-76-9110; 4/15/65
Richard Dillon; 1700 Main Street #621, Vancouver, WA 98660; 523-88-6409; 1/17/57
Ronald Odermott; 45409 NE Yale Bridge Road, Amboy, WA 98601; 541-70-6986; 12/26/64

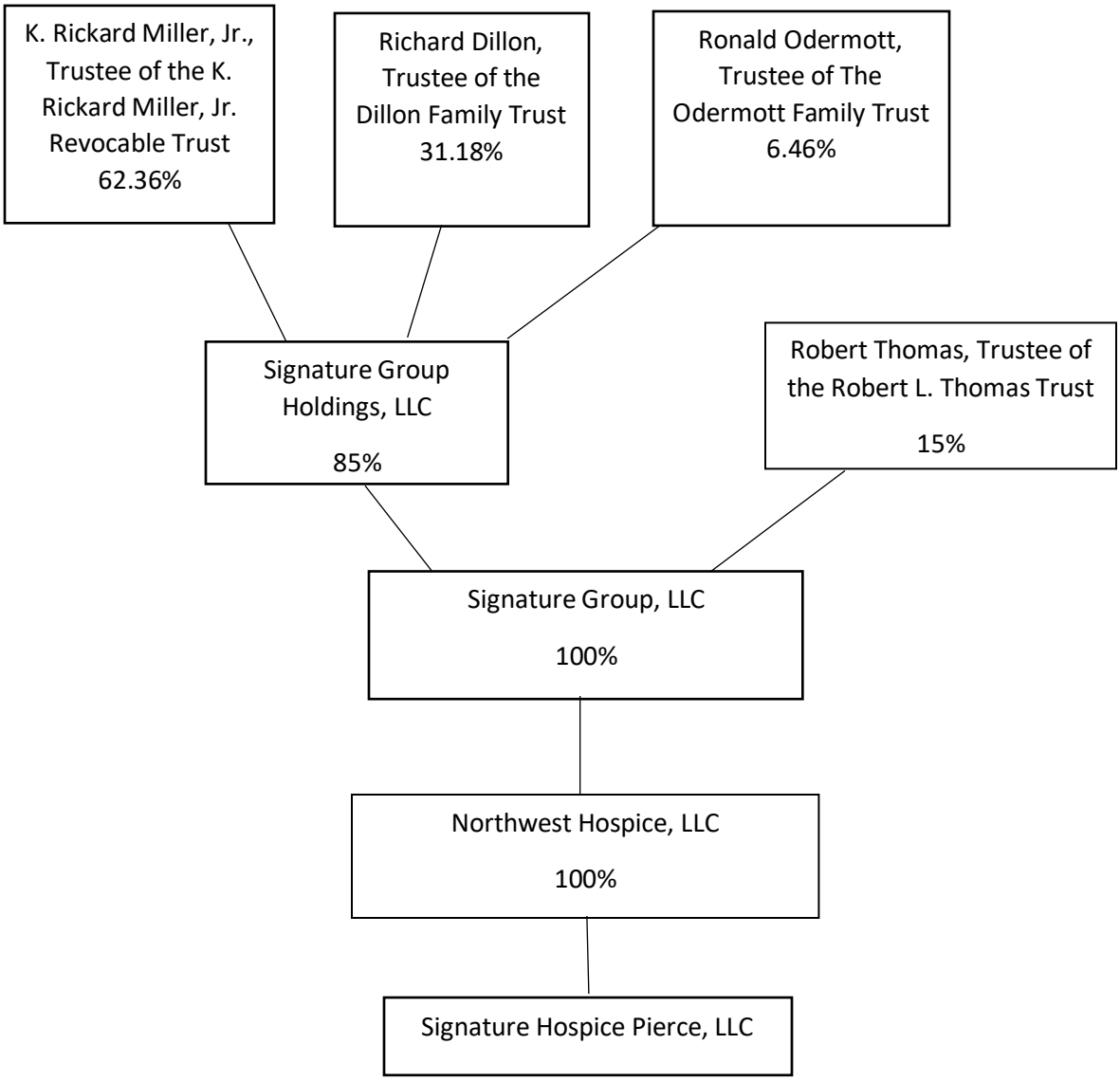


**EXHIBIT 2: Signature Hospice Pierce Washington State Entity Registration**

UNITED STATES OF AMERICA

# The State of Washington

## Secretary of State

**I, KIM WYMAN**, Secretary of State of the State of Washington and custodian of its seal, hereby issue this

**CERTIFICATE OF FORMATION**

to

**SIGNATURE HOSPICE PIERCE, LLC**

A **WA LIMITED LIABILITY COMPANY**, effective on the date indicated below.

Effective Date: 12/03/2019
UBI Number: 604 544 521

Given under my hand and the Seal of the State of Washington at Olympia, the State Capital

Kim Wyman

Kim Wyman, Secretary of State

Date Issued: 12/03/2019

Office of the Secretary of State
Corporations & Charities Division
(360) 725 - 0377 | www.sos.wa.gov/corps
801 Capitol Way S, Olympia, WA 98504-0234

This Box For Office Use Only

FILED
Signature Hospice Pierce, LLC
Secretary of State
State of Washington
Date Filed: 12/03/2019
Effective Date: 12/03/2019
UBI No: 604 544 521

☐ Filing Fee $180

☐ Filing Fee with Expedited Service $230

# Certificate of Formation
# Limited Liability Company
# RCW 25.15

Do you already have a UBI Number? (Check one) ☐ Yes ☒ No If Yes, provide UBI # _____

If No, a new UBI# will be issued to you upon successful completion of the filing.

If you have previously filed with another state agency (for example, the Department of Revenue, the Department of Labor and Industries, or the Employment Security Department), you may already have a 9 digit UBI Number that you can enter above. Please do not enter the UBI Number of a Sole Proprietorship or General Partnership. If you do not have a UBI Number, please select "no" above and continue with the filing.

**ENTITY NAME :**

Does the entity have a name reserved? (Check one) ☐ Yes ☑ No

If Yes, provide the Name Reservation Number and Name If No, provide only the name

Reservation Number: _____

Name: Signature Hospice Pierce, LLC

**For name requirements review the following RCW(s): Limited Liability Company - RCW 23.95.305 (5)**

**PERIOD OF DURATION :** Please check **ONE** of the following

☒ This Company shall have a perpetual duration (default) ☐ This Company shall have a duration of _____ years.

☐ This Company shall expire on _____

**EFFECTIVE DATE:** Please check **ONE** of the following:

☒ Date of filing ☐ Specify a Date _____ cannot be more than 90 days following received date

**REGISTERED AGENT:**

Is the Registered Agent a Commercial Registered Agent? ☒ Yes ☐ No

If Yes, provide the name of the Commercial Registered Agent: National Registered Agents, Inc.

A Commercial Registered Agent is an entity or individual that is registered with the Office of the Secretary of State to receive legal documents on behalf of a corporation. A Commercial Registered Agent has the entities/individual's address on record with the office.

**A Registered Agent consent is still required for a Commercial Registered Agent located below.**

If No, please continue below

**Please complete ONE type of Registered Agent below, be sure to include the name below the checked box. Then continue to provide the required street address. Mailing address if needed.**

| ☐ Individual | ☐ Entity | ☐ Office or Position |
|---|---|---|
| First and last name of a Non-commercial Registered Agent. (Any person not registered as a Commercial Registered Agent.) | Name of a Non-commercial Registered Agent. (Any business not registered as a Commercial Registered Agent.) | List the Office or Position serves as agent. (Only if using the specific office or position as the registered agent, no matter who holds the position like: Secretary, Member or Treasurer.) |

Phone: _____ Email: _____

**Registered Agent Street Address (required)**
**(Must be a physical address No PO Box or PMB)**

**Country: United States** **State: Washington**

**Address :** _____

**Zip:** _____ **City:** _____

**Registered Agent Mailing Address** (optional)
☐ Check if mailing address is the same as street address

**Country: United States** **State: Washington**

**Address :** _____

**Zip:** _____ **City:** _____

**CONSENT TO SERVE AS REGISTERED AGENT - REQUIRED FOR ALL TYPES**

I hereby consent to serve as Registered Agent in the State of Washington for the named entity. I understand it will be my responsibility to accept service of process, notices, and demands on behalf of the entity; to forward mail to the entity; and to immediately notify the Office of the Secretary of State if I resign or change the Registered Office Address.

National Registered Agents, Inc.

By: Corinne Games Corinne Games - Asst Sec 12-4-19

Signature of Registered Agent | Printed Name/Title | Date

| Principal Office Street Address (Must be a physical address; No PO Box or PMB) | Mailing Address (optional) ☐ Check if mailing address is the same as street address. |
|---|---|
| Address: 25117 SW Parkway, Suite F | Address: |
| Zip: 97070 City: Wilsonville | Zip: City: |
| State: OR Country: USA | State: Country: |

Phone: (optional) Email: (optional)

**RETURN ADDRESS FOR THIS FILING:** *(Optional)*

This address will be sent document( s) regarding this specific filing in addition to document (s) being sent to the Registered Agent's street/mailing address.

Attention to: Lawrence Lopardo

Email: lawlopardo@avamere.com

Address: 25117 SW Parkway, Suite F

City Wilsonville State OR Zip 97070

**EXECUTOR INFORMATION:**

Name, address, and signature required. Attach additional sheets if necessary.

This record is hereby executed under penalties of perjury, and is, to the best of my knowledge, true and correct.

Address: 25117 SW Parkway, Suite F

City Wilsonville State OR Zip 97070

DocuSigned by: lawrence lopardo A447894061E9442...

Signature of Executor | Lawrence Lopardo, Chief Legal Officer | 11/26/2019

Signature of Executor | Printed Name/Title | Date

Office of the Secretary of State
Corporations & Charities Division

James M. Dolliver Building
801 Capitol Way South • PO Box 40234
Olympia, WA 98504-0234
Tel: 360.725.0377
www.sos.wa.gov/corps



Congratulations:

You have completed the initial filing to create a new business entity. **The next step in opening your new business is to complete a Business License Application.** You may have completed this step already. The Business License Application can be completed online or downloaded at: http://www.bls.dor.wa.gov/.

If you have any questions about the Business License Application, or would like a Business License Application package mailed to you, please call the Department of Revenue at 1-800-451-7985.

If you have questions about annual reports or registered agent requirements, please contact the Corporations Division at 360-725-0377 or visit our website at: http://www.sos.wa.gov/corps.

NATIONAL REGISTERED AGENTS, INC.
711 CAPITOL WAY S STE 204
OLYMPIA WA 98501-1267

## IMPORTANT

To keep your filing status active and avoid administrative dissolution, you must:

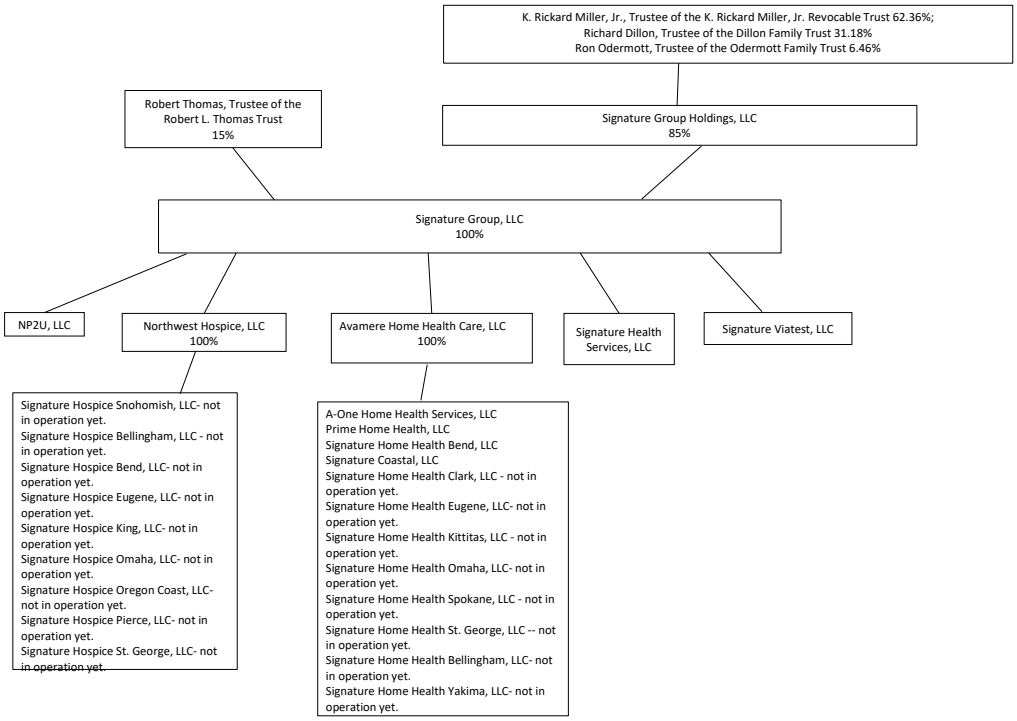
1. **File an Initial Report** within 120 days of the date your corporation or limited liability company (LLC) was filed. The date of filing is stated on your certificate. Please go online to file your initial report at www.sos.wa.gov/ccfs.

2. **File an Annual Report** each year before the anniversary of the filing date for the entity. The registered agent will be sent notice of the Annual Report requirement. It is the corporation or LLC's responsibility to file the report on time even if no notice is received.

3. **Maintain a Registered Agent** and registered office in this state. You must file a statement of change or designation of registered agent if there are any changes in your registered agent, agent's address, or registered office address. Failure to file changes with the Corporations Division will result in misrouted mail, and possibly lead to administrative dissolution.

If you have questions please contact our office at: corps@sos.wa.gov, 360-725-0377, or visit our website www.sos.wa.gov/corps.

**EXHIBIT 3: Signature Group, LLC Organizational Chart**


K. Rickard Miller, Jr., Trustee of the K. Rickard Miller, Jr. Revocable Trust 62.36%;
Richard Dillon, Trustee of the Dillon Family Trust 31.18%
Ron Odermott, Trustee of the Odermott Family Trust 6.46%
Robert Thomas, Trustee of the Robert L. Thomas Trust 15%
Signature Group Holdings, LLC 85%
Signature Group, LLC 100%
NP2U, LLC
Northwest Hospice, LLC 100%
Avamere Home Health Care, LLC 100%
Signature Health Services, LLC
Signature Viatest, LLC
Signature Hospice Snohomish, LLC- not in operation yet.
Signature Hospice Bellingham, LLC - not in operation yet.
Signature Hospice Bend, LLC- not in operation yet.
Signature Hospice Eugene, LLC- not in operation yet.
Signature Hospice King, LLC- not in operation yet.
Signature Hospice Omaha, LLC- not in operation yet.
Signature Hospice Oregon Coast, LLC- not in operation yet.
Signature Hospice Pierce, LLC- not in operation yet.
Signature Hospice St. George, LLC- not in operation yet.
A-One Home Health Services, LLC
Prime Home Health, LLC
Signature Home Health Bend, LLC
Signature Coastal, LLC
Signature Home Health Clark, LLC - not in operation yet.
Signature Home Health Eugene, LLC- not in operation yet.
Signature Home Health Kittitas, LLC - not in operation yet.
Signature Home Health Omaha, LLC- not in operation yet.
Signature Home Health Spokane, LLC - not in operation yet.
Signature Home Health St. George, LLC -- not in operation yet.
Signature Home Health Bellingham, LLC- not in operation yet.
Signature Home Health Yakima, LLC- not in operation yet.

## EXHIBIT 4: Signature Healthcare at Home Location Information

# Signature Healthcare at Home
# Current Home Health and Hospice Locations

## OREGON

**EUGENE**
2620 River Road
Eugene, OR 97404
**Home Health:** 541-461-0325
Lic No:13-1391
PTAN: 38-7140
**Hospice:** 541-689-3508
Lic No: 16-1050
PTAN: 38-1553
**Home Care:** 541-246-1550
Lic No: 15-2259

**ALBANY**
317 W 1st Ave, Suite 301
Albany, OR 97321
**Home Health**: 541-812-5254
Lic No:13-1391
PTAN: 38-7140

**PORTLAND**
7632 SW Durham Road
Tigard, OR 97224
**Home Health:** 503-783-2470
Lic No:13-1376
PTAN: 38-7148
**Hospice:** 1-800-936-4756
Lic No: 16-1050
PTAN: 38-1553

**SALEM**
1220 20th St SE
Salem, OR 97302
**Home Health:** 503-364-0347
Lic No:13-1376
PTAN: 38-7148
**Hospice:** 503-364-0347
Lic No: 16-1050
PTAN: 38-1553

**MEDFORD**
834 South Front St
Medford, OR 97502
**Home Health**: 541-664-7400
Lic No:13-1389

PTAN: 38-7142
**Hospice**: 541-664-7400
Lic No:16-1061
PTAN: 38-1560
**Home Care**: 541-664-9684
Lic No: 15-2258

**OREGON COAST**
1547 North Coast Hwy
Newport, OR 97365
**Home Health:** 541-264-7823
Lic No: 13-1538
PTAN: 38-7077

**BEND**
454 NE Revere Ave
Bend, OR 97701
**Home Care**: 541-382-5050
License pending

## WASHINGTON

**BELLEVUE/SEATTLE**
1510 140th Avenue NE
Bellevue, WA 98005
**Home Health:** 425-747-774
Lic No: HIS.FS.00000220
PTAN: 50-7100

**BELLINGHAM**
459 Stuart Avenue
Bellingham, WA 98226
**Home Health:** 360-671-5872
Lic No: HIS.FS.00000089
PTAN: 50-7116

**FEDERAL WAY**
909 S 336th Street
Federal Way, WA 98003
**Home Health:** 253-661-5166
Lic No: HIS.FS.00000382
PTAN: 50-7110

## UTAH

**GREATER SALT LAKE CITY**
5965 South 900 East
Murray, UT 84121

**Home Health:** 801-463-2478
Lic No: 2020-HHA-UT000148
PTAN: 46-7121
**Hospice:** 801-463-2478
Lic No: 2020-Hospice-UT000175
PTAN: 46-1554
**House Calls:** 801-746-7434

## IDAHO

**BOISE-NAMPA**
3904 E. Flamingo Ave
Nampa, ID 83687

**Home Health:** 208-465-7121
Lic No: HH-269
PTAN: 13-7135
Accredited by ACHC
**Hospice:** 208-465-7121
Lic No: NA
PTAN:13-1510
**Housecalls:** 208-465-7121

**PAYETTE**
1000 S 16th St.
Payette, ID 83661

**Home Health:** 208-642-9222
Lic No: HH-269
PTAN: 13-7135
Accredited by ACHC
**Hospice:** 208-642-9222
Lic No: NA
PTAN:13-1510
**Housecalls:** 208-642-9222

## CORPORATE OFFICE

25117 SW Parkway, Suite F
Wilsonville, OR 97070
971-224-2829

**EXHIBIT 5: Signature Hospice Pierce, LLC Letter of Intent**

SIGNATURE healthcare at home
care where you are

December 7, 2020

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

Re: Signature Hospice Pierce, LLC Letter of Intent for Hospice Services

To Whom It May Concern:

Signature Hospice Pierce, LLC is pleased to provide you with this Letter of Intent indicating our desire to provide Hospice Services in Pierce County, Washington. In accordance with WAC 246-310-080 and WAC 246-310-290, we are providing the following information regarding the proposed services Signature Hospice would offer to the community.

1. **DESCRIPTION OF SERVICES PROPOSED**
   Signature Hospice Pierce, LLC proposes a new location in Pierce County to provide Hospice services to the growing community. The expansion into hospice services will provide a continuum of care with an existing Signature Home Health agency.

2. **ESTIMATED COST**
   Initial start-up costs of $12,500

3. **SERVICE AREA**
   Signature Hospice Pierce, LLC will provide services in the Pierce County planning area, as identified in WAC 246-310-080.

Sincerely,

DocuSigned by:
Mary Kofstad
73A96D5B1B014F9...

Mary Kofstad,
Division President
Signature Healthcare at Home
mkofstad@4signatureservice.com
971-224-2033

**EXHIBIT 6: 2020-2022 DOH Hospice Need Methodology**

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Signature Hospice Pierce, LLC

Washington State Department of Health

**WAC246-310-290(8)(a) Step 1:**

**Calculate the following two statewide predicted hospice use rates using department of health survey and vital statistics data:**

WAC 246-310-290(8)(a)(i) The percentage of patients age sixty-five and over who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients sixty five and over by the average number of past three years statewide total deaths age sixty-five and over.
WAC246-310-290(8)(a)(ii) The percentage of patients under sixty-five who will use hospice services. This percentage is calculated by dividing the average number of unduplicated admissions over the last three years for patients under sixty-five by the average number of past three years statewide total of deaths under sixty-five.

| Hospice admissions ages 0-64 | | |
|---|---|---|
| Year | Admissions | |
| 2017 | 3,757 | |
| 2018 | 4,114 | |
| 2019 | 3,699 | |
| | **average:** | **3,857** |

| Deaths ages 0-64 | | |
|---|---|---|
| Year | Deaths | |
| 2017 | 14,113 | |
| 2018 | 14,055 | |
| 2019 | 14,047 | |
| | **average:** | **14,072** |

| Use Rates | |
|---|---|
| 0-64 | 27.41% |
| 65+ | 60.52% |

| Hospice admissions ages 65+ | | |
|---|---|---|
| Year | Admissions | |
| 2017 | 26,365 | |
| 2018 | 26,207 | |
| 2019 | 26,017 | |
| | **average:** | **26,196** |

| Deaths ages 65+ | | |
|---|---|---|
| Year | Deaths | |
| 2017 | 42,918 | |
| 2018 | 42,773 | |
| 2019 | 44,159 | |
| | **average:** | **43,283** |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

# Department of Health
## 2020-2021 Hospice Numeric Need Methodology
*Posted October 30, 2020*

**WAC246-310-290(8)(b) Step 2:**
**Calculate the average number of total resident deaths over the last three years for each planning area by age cohort.**

| 0-64 | | | | |
|---|---|---|---|---|
| County | 2017 | 2018 | 2019 | 2017-2019 Average Deaths |
| **Adams** | 38 | 28 | 35 | **34** |
| **Asotin** | 49 | 52 | 54 | **52** |
| **Benton** | 385 | 331 | 346 | **354** |
| **Chelan** | 124 | 130 | 137 | **130** |
| **Clallam** | 180 | 191 | 186 | **186** |
| **Clark** | 883 | 874 | 887 | **881** |
| **Columbia** | 19 | 6 | 7 | **11** |
| **Cowlitz** | 351 | 300 | 294 | **315** |
| **Douglas** | 71 | 51 | 63 | **62** |
| **Ferry** | 30 | 28 | 20 | **26** |
| **Franklin** | 133 | 145 | 123 | **134** |
| **Garfield** | 6 | 5 | 5 | **5** |
| **Grant** | 203 | 195 | 197 | **198** |
| **Grays Harbor** | 238 | 227 | 251 | **239** |
| **Island** | 166 | 135 | 167 | **156** |
| **Jefferson** | 69 | 64 | 72 | **68** |
| **King** | 3,256 | 3,264 | 3,275 | **3,265** |
| **Kitsap** | 485 | 515 | 557 | **519** |
| **Kittitas** | 91 | 68 | 90 | **83** |
| **Klickitat** | 63 | 58 | 46 | **56** |
| **Lewis** | 210 | 227 | 210 | **216** |
| **Lincoln** | 20 | 25 | 25 | **23** |
| **Mason** | 169 | 158 | 167 | **165** |
| **Okanogan** | 119 | 103 | 119 | **114** |
| **Pacific** | 88 | 64 | 66 | **73** |
| **Pend Oreille** | 34 | 43 | 31 | **36** |
| **Pierce** | 1,936 | 1,964 | 1,911 | **1,937** |
| **San Juan** | 18 | 19 | 20 | **19** |
| **Skagit** | 271 | 231 | 229 | **244** |
| **Skamania** | 16 | 27 | 19 | **21** |
| **Snohomish** | 1,483 | 1,533 | 1,533 | **1,516** |
| **Spokane** | 1,147 | 1,177 | 1,143 | **1,156** |
| **Stevens** | 96 | 113 | 112 | **107** |
| **Thurston** | 530 | 554 | 525 | **536** |
| **Wahkiakum** | 3 | 13 | 11 | **9** |
| **Walla Walla** | 123 | 110 | 118 | **117** |
| **Whatcom** | 367 | 360 | 394 | **374** |
| **Whitman** | 57 | 66 | 47 | **57** |
| **Yakima** | 586 | 601 | 555 | **581** |

| 65+ | | | | |
|---|---|---|---|---|
| County | 2017 | 2018 | 2019 | 2017-2019 Average Deaths |
| **Adams** | 78 | 72 | 93 | **81** |
| **Asotin** | 190 | 214 | 222 | **209** |
| **Benton** | 1,081 | 1,125 | 1,154 | **1,120** |
| **Chelan** | 556 | 573 | 626 | **585** |
| **Clallam** | 842 | 871 | 955 | **889** |
| **Clark** | 2,579 | 2,767 | 2,987 | **2,778** |
| **Columbia** | 116 | 43 | 52 | **70** |
| **Cowlitz** | 917 | 840 | 951 | **903** |
| **Douglas** | 232 | 255 | 270 | **252** |
| **Ferry** | 60 | 55 | 64 | **60** |
| **Franklin** | 284 | 278 | 313 | **292** |
| **Garfield** | 17 | 30 | 21 | **23** |
| **Grant** | 509 | 524 | 508 | **514** |
| **Grays Harbor** | 622 | 647 | 659 | **643** |
| **Island** | 630 | 675 | 642 | **649** |
| **Jefferson** | 308 | 336 | 338 | **327** |
| **King** | 10,039 | 9,917 | 10,213 | **10,056** |
| **Kitsap** | 1,780 | 1,713 | 1,811 | **1,768** |
| **Kittitas** | 237 | 239 | 266 | **247** |
| **Klickitat** | 151 | 158 | 160 | **156** |
| **Lewis** | 721 | 730 | 722 | **724** |
| **Lincoln** | 105 | 94 | 89 | **96** |
| **Mason** | 550 | 526 | 548 | **541** |
| **Okanogan** | 350 | 332 | 358 | **347** |
| **Pacific** | 262 | 279 | 265 | **269** |
| **Pend Oreille** | 133 | 130 | 125 | **129** |
| **Pierce** | 5,019 | 4,926 | 5,002 | **4,982** |
| **San Juan** | 115 | 114 | 127 | **119** |
| **Skagit** | 1,007 | 1,001 | 1,018 | **1,009** |
| **Skamania** | 65 | 56 | 87 | **69** |
| **Snohomish** | 4,118 | 4,055 | 4,081 | **4,085** |
| **Spokane** | 3,527 | 3,556 | 3,545 | **3,543** |
| **Stevens** | 376 | 373 | 345 | **365** |
| **Thurston** | 1,768 | 1,823 | 1,908 | **1,833** |
| **Wahkiakum** | 37 | 33 | 53 | **41** |
| **Walla Walla** | 501 | 445 | 450 | **465** |
| **Whatcom** | 1,329 | 1,252 | 1,461 | **1,347** |
| **Whitman** | 236 | 199 | 219 | **218** |
| **Yakima** | 1,471 | 1,517 | 1,451 | **1,480** |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

# Department of Health
## 2020-2021 Hospice Numeric Need Methodology
*Posted October 30, 2020*

**WAC246-310-290(8)(c) Step 3.**
**Multiply each hospice use rate determined in Step 1 by the planning areas' average total resident deaths determined in Step 2, separated by age cohort.**

| 0-64 | | |
|---|---|---|
| County | 2017-2019 Average Deaths | Projected Patients: 27.38% of Deaths |
| Adams | 34 | 9 |
| Asotin | 52 | 14 |
| Benton | 354 | 97 |
| Chelan | 130 | 36 |
| Clallam | 186 | 51 |
| Clark | 881 | 242 |
| Columbia | 11 | 3 |
| Cowlitz | 315 | 86 |
| Douglas | 62 | 17 |
| Ferry | 26 | 7 |
| Franklin | 134 | 37 |
| Garfield | 5 | 1 |
| Grant | 198 | 54 |
| Grays Harbor | 239 | 65 |
| Island | 156 | 43 |
| Jefferson | 68 | 19 |
| King | 3,265 | 895 |
| Kitsap | 519 | 142 |
| Kittitas | 83 | 23 |
| Klickitat | 56 | 15 |
| Lewis | 216 | 59 |
| Lincoln | 23 | 6 |
| Mason | 165 | 45 |
| Okanogan | 114 | 31 |
| Pacific | 73 | 20 |
| Pend Oreille | 36 | 10 |
| Pierce | 1,937 | 531 |
| San Juan | 19 | 5 |
| Skagit | 244 | 67 |
| Skamania | 21 | 6 |
| Snohomish | 1,516 | 416 |
| Spokane | 1,156 | 317 |
| Stevens | 107 | 29 |
| Thurston | 536 | 147 |
| Wahkiakum | 9 | 2 |
| Walla Walla | 117 | 32 |
| Whatcom | 374 | 102 |
| Whitman | 57 | 16 |
| Yakima | 581 | 159 |

| 65+ | | |
|---|---|---|
| County | 2017-2019 Average Deaths | Projected Patients: 61.04% of Deaths |
| Adams | 81 | 49 |
| Asotin | 209 | 126 |
| Benton | 1,120 | 678 |
| Chelan | 585 | 354 |
| Clallam | 889 | 538 |
| Clark | 2,778 | 1,681 |
| Columbia | 70 | 43 |
| Cowlitz | 903 | 546 |
| Douglas | 252 | 153 |
| Ferry | 60 | 36 |
| Franklin | 292 | 177 |
| Garfield | 23 | 14 |
| Grant | 514 | 311 |
| Grays Harbor | 643 | 389 |
| Island | 649 | 393 |
| Jefferson | 327 | 198 |
| King | 10,056 | 6,086 |
| Kitsap | 1,768 | 1,070 |
| Kittitas | 247 | 150 |
| Klickitat | 156 | 95 |
| Lewis | 724 | 438 |
| Lincoln | 96 | 58 |
| Mason | 541 | 328 |
| Okanogan | 347 | 210 |
| Pacific | 269 | 163 |
| Pend Oreille | 129 | 78 |
| Pierce | 4,982 | 3,015 |
| San Juan | 119 | 72 |
| Skagit | 1,009 | 610 |
| Skamania | 69 | 42 |
| Snohomish | 4,085 | 2,472 |
| Spokane | 3,543 | 2,144 |
| Stevens | 365 | 221 |
| Thurston | 1,833 | 1,109 |
| Wahkiakum | 41 | 25 |
| Walla Walla | 465 | 282 |
| Whatcom | 1,347 | 815 |
| Whitman | 218 | 132 |
| Yakima | 1,480 | 896 |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Signature Hospice Pierce, LLC

Washington State Department of Health

**WAC246-310-290(8)(d) Step 4:**
**Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.**

| 0-64 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| County | Projected Patients | 2017-2019 Average Population | 2020 projected population | 2021 projected population | 2022 projected population | 2020 potential volume | 2021 potential volume | 2022 potential volume |
| Adams | 9 | 18,029 | 18,291 | 18,456 | 18,622 | 9 | 9 | 10 |
| Asotin | 14 | 16,779 | 16,652 | 16,596 | 16,540 | 14 | 14 | 14 |
| Benton | 97 | 166,554 | 169,415 | 171,026 | 172,638 | 99 | 100 | 101 |
| Chelan | 36 | 61,991 | 62,463 | 62,512 | 62,562 | 36 | 36 | 36 |
| Clallam | 51 | 52,550 | 52,439 | 52,233 | 52,027 | 51 | 51 | 50 |
| Clark | 242 | 405,282 | 417,273 | 421,901 | 426,529 | 249 | 251 | 254 |
| Columbia | 3 | 2,863 | 2,780 | 2,745 | 2,710 | 3 | 3 | 3 |
| Cowlitz | 86 | 85,717 | 85,917 | 85,843 | 85,769 | 87 | 86 | 86 |
| Douglas | 17 | 34,732 | 35,527 | 35,803 | 36,080 | 17 | 17 | 18 |
| Ferry | 7 | 5,680 | 5,577 | 5,541 | 5,506 | 7 | 7 | 7 |
| Franklin | 37 | 85,922 | 90,102 | 92,443 | 94,784 | 38 | 39 | 40 |
| Garfield | 1 | 1,602 | 1,560 | 1,541 | 1,522 | 1 | 1 | 1 |
| Grant | 54 | 84,909 | 87,158 | 88,240 | 89,322 | 56 | 56 | 57 |
| Grays Harbor | 65 | 57,817 | 56,958 | 56,679 | 56,401 | 64 | 64 | 64 |
| Island | 43 | 62,964 | 63,264 | 63,280 | 63,296 | 43 | 43 | 43 |
| Jefferson | 19 | 20,688 | 20,722 | 20,636 | 20,550 | 19 | 19 | 19 |
| King | 895 | 1,863,482 | 1,906,749 | 1,918,470 | 1,930,192 | 916 | 921 | 927 |
| Kitsap | 142 | 217,040 | 220,035 | 220,614 | 221,192 | 144 | 145 | 145 |
| Kittitas | 23 | 37,892 | 39,015 | 39,286 | 39,556 | 23 | 24 | 24 |
| Klickitat | 15 | 15,828 | 15,575 | 15,439 | 15,304 | 15 | 15 | 15 |
| Lewis | 59 | 62,398 | 63,001 | 63,164 | 63,327 | 60 | 60 | 60 |
| Lincoln | 6 | 7,923 | 7,805 | 7,751 | 7,698 | 6 | 6 | 6 |
| Mason | 45 | 50,142 | 51,122 | 51,397 | 51,672 | 46 | 46 | 47 |
| Okanogan | 31 | 32,545 | 32,183 | 32,087 | 31,991 | 31 | 31 | 31 |
| Pacific | 20 | 14,688 | 14,403 | 14,322 | 14,242 | 20 | 19 | 19 |
| Pend Oreille | 10 | 9,905 | 9,812 | 9,769 | 9,727 | 10 | 10 | 10 |
| Pierce | 531 | 747,538 | 765,139 | 769,918 | 774,696 | 543 | 547 | 550 |
| San Juan | 5 | 10,974 | 10,753 | 10,730 | 10,707 | 5 | 5 | 5 |
| Skagit | 67 | 100,076 | 101,537 | 101,887 | 102,236 | 68 | 68 | 68 |
| Skamania | 6 | 9,254 | 9,242 | 9,223 | 9,205 | 6 | 6 | 6 |
| Snohomish | 416 | 694,793 | 716,781 | 721,527 | 726,273 | 429 | 432 | 434 |
| Spokane | 317 | 421,066 | 425,447 | 426,740 | 428,033 | 320 | 321 | 322 |
| Stevens | 29 | 34,226 | 33,992 | 33,917 | 33,841 | 29 | 29 | 29 |
| Thurston | 147 | 234,880 | 241,500 | 243,867 | 246,235 | 151 | 153 | 154 |
| Wahkiakum | 2 | 2,555 | 2,441 | 2,405 | 2,368 | 2 | 2 | 2 |
| Walla Walla | 32 | 50,546 | 50,981 | 51,028 | 51,075 | 32 | 32 | 32 |
| Whatcom | 102 | 183,023 | 187,812 | 189,267 | 190,722 | 105 | 106 | 107 |
| Whitman | 16 | 43,137 | 43,308 | 43,315 | 43,322 | 16 | 16 | 16 |
| Yakima | 159 | 221,051 | 224,497 | 225,822 | 227,147 | 162 | 163 | 164 |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Washington State Department of Health

**WAC246-310-290(8)(d) Step 4:**
**Using the projected patients calculated in Step 3, calculate a use rate by dividing projected patients by the three-year historical average population by county. Use this rate to determine the potential volume of hospice use by the projected population by age cohort using Office of Financial Management (OFM) data.**

| 65+ | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| County | Projected Patients | 2017-2019 Average Population | 2020 projected population | 2021 projected population | 2022 projected population | 2020 potential volume | 2021 potential volume | 2022 potential volume |
| Adams | 49 | 2,114 | 2,341 | 2,383 | 2,424 | 54 | 55 | 56 |
| Asotin | 126 | 5,619 | 6,005 | 6,175 | 6,344 | 135 | 139 | 143 |
| Benton | 678 | 29,821 | 32,150 | 33,373 | 34,597 | 731 | 759 | 786 |
| Chelan | 354 | 15,343 | 16,408 | 17,052 | 17,695 | 379 | 393 | 408 |
| Clallam | 538 | 21,334 | 22,267 | 22,901 | 23,535 | 562 | 578 | 594 |
| Clark | 1681 | 75,085 | 82,125 | 85,686 | 89,247 | 1,839 | 1,918 | 1,998 |
| Columbia | 43 | 1,202 | 1,269 | 1,287 | 1,304 | 45 | 46 | 46 |
| Cowlitz | 546 | 21,326 | 22,969 | 23,719 | 24,470 | 588 | 608 | 627 |
| Douglas | 153 | 7,595 | 8,358 | 8,666 | 8,974 | 168 | 174 | 180 |
| Ferry | 36 | 2,095 | 2,241 | 2,289 | 2,337 | 39 | 39 | 40 |
| Franklin | 177 | 8,765 | 9,610 | 10,083 | 10,557 | 194 | 203 | 213 |
| Garfield | 14 | 633 | 658 | 669 | 680 | 14 | 15 | 15 |
| Grant | 311 | 14,244 | 15,477 | 16,071 | 16,665 | 338 | 351 | 364 |
| Grays Harbor | 389 | 15,594 | 16,653 | 17,133 | 17,612 | 415 | 427 | 439 |
| Island | 393 | 19,701 | 20,777 | 21,412 | 22,047 | 414 | 427 | 440 |
| Jefferson | 198 | 11,252 | 11,924 | 12,323 | 12,722 | 210 | 217 | 224 |
| King | 6086 | 296,484 | 324,660 | 337,771 | 350,881 | 6,665 | 6,934 | 7,203 |
| Kitsap | 1070 | 51,788 | 55,878 | 58,185 | 60,492 | 1,155 | 1,202 | 1,250 |
| Kittitas | 150 | 7,351 | 7,943 | 8,266 | 8,589 | 162 | 168 | 175 |
| Klickitat | 95 | 5,570 | 6,088 | 6,268 | 6,448 | 103 | 106 | 110 |
| Lewis | 438 | 16,398 | 17,219 | 17,697 | 18,175 | 460 | 473 | 486 |
| Lincoln | 58 | 2,823 | 2,959 | 3,039 | 3,119 | 61 | 63 | 64 |
| Mason | 328 | 15,311 | 16,499 | 17,167 | 17,836 | 353 | 367 | 382 |
| Okanogan | 210 | 10,050 | 10,901 | 11,210 | 11,519 | 228 | 234 | 240 |
| Pacific | 163 | 6,584 | 6,910 | 7,035 | 7,159 | 171 | 174 | 177 |
| Pend Oreille | 78 | 3,742 | 4,107 | 4,239 | 4,371 | 86 | 89 | 91 |
| Pierce | 3015 | 125,262 | 136,114 | 142,422 | 148,729 | 3,277 | 3,429 | 3,580 |
| San Juan | 72 | 5,545 | 5,991 | 6,174 | 6,357 | 78 | 80 | 82 |
| Skagit | 610 | 26,595 | 29,168 | 30,314 | 31,460 | 670 | 696 | 722 |
| Skamania | 42 | 2,542 | 2,798 | 2,923 | 3,048 | 46 | 48 | 50 |
| Snohomish | 2472 | 113,447 | 125,219 | 131,978 | 138,737 | 2,729 | 2,876 | 3,023 |
| Spokane | 2144 | 84,343 | 91,361 | 94,670 | 97,979 | 2,323 | 2,407 | 2,491 |
| Stevens | 221 | 10,884 | 11,837 | 12,214 | 12,591 | 240 | 248 | 255 |
| Thurston | 1109 | 48,683 | 52,832 | 54,900 | 56,967 | 1,204 | 1,251 | 1,298 |
| Wahkiakum | 25 | 1,441 | 1,565 | 1,580 | 1,595 | 27 | 27 | 27 |
| Walla Walla | 282 | 10,944 | 11,068 | 11,350 | 11,632 | 285 | 292 | 299 |
| Whatcom | 815 | 39,164 | 42,640 | 44,217 | 45,794 | 888 | 921 | 953 |
| Whitman | 132 | 5,237 | 5,815 | 6,008 | 6,201 | 146 | 151 | 156 |
| Yakima | 896 | 36,670 | 38,391 | 39,475 | 40,559 | 938 | 964 | 991 |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

# Department of Health
## 2020-2021 Hospice Numeric Need Methodology
*Posted October 30, 2020*

**WAC246-310-290(8)(e) Step 5:**
**Combine the two age cohorts. Subtract the average of the most recent three years hospice capacity in each planning area from the projected volumes calculated in Step 4 to determine the number of projected admissions beyond the planning area capacity.**

| County | 2020 potential volume | 2021 potential volume | 2022 potential volume | Current Supply of Hospice Providers | 2020 Unmet Need Admissions* | 2021 Unmet Need Admissions* | 2022 Unmet Need Admissions* |
|---|---|---|---|---|---|---|---|
| **Adams** | 64 | 65 | 66 | **45.33** | 18 | 19 | 20 |
| **Asotin** | 149 | 153 | 157 | **99.67** | 49 | 53 | 57 |
| **Benton** | 829 | 858 | 887 | **976.67** | (147) | (118) | (90) |
| **Chelan** | 415 | 430 | 444 | **398.67** | 16 | 31 | 46 |
| **Clallam** | 613 | 628 | 644 | **273.63** | 339 | 355 | 371 |
| **Clark** | 2,087 | 2,170 | 2,252 | **2,396.97** | (310) | (227) | (145) |
| **Columbia** | 48 | 48 | 49 | **23.33** | 24 | 25 | 26 |
| **Cowlitz** | 675 | 694 | 713 | **794.00** | (119) | (100) | (81) |
| **Douglas** | 185 | 192 | 198 | **147.67** | 38 | 44 | 50 |
| **Ferry** | 46 | 46 | 47 | **36.33** | 9 | 10 | 11 |
| **Franklin** | 232 | 242 | 253 | **171.33** | 61 | 71 | 82 |
| **Garfield** | 16 | 16 | 16 | **3.33** | 12 | 13 | 13 |
| **Grant** | 394 | 407 | 421 | **281.00** | 113 | 126 | 140 |
| **Grays Harbor** | 480 | 491 | 503 | **277.33** | 202 | 214 | 226 |
| **Island** | 457 | 470 | 483 | **389.67** | 68 | 80 | 93 |
| **Jefferson** | 229 | 236 | 243 | **188.00** | 41 | 48 | 55 |
| **King** | 7,580 | 7,855 | 8,130 | **7,517.23** | 63 | 338 | 613 |
| **Kitsap** | 1,299 | 1,347 | 1,395 | **1,303.97** | (5) | 43 | 91 |
| **Kittitas** | 185 | 192 | 199 | **171.67** | 13 | 20 | 27 |
| **Klickitat** | 118 | 121 | 124 | **277.57** | (159) | (156) | (153) |
| **Lewis** | 520 | 533 | 546 | **451.00** | 69 | 82 | 95 |
| **Lincoln** | 67 | 69 | 70 | **28.67** | 39 | 40 | 42 |
| **Mason** | 399 | 414 | 428 | **222.67** | 176 | 191 | 206 |
| **Okanogan** | 258 | 265 | 271 | **177.67** | 81 | 87 | 93 |
| **Pacific** | 190 | 193 | 196 | **107.00** | 83 | 86 | 89 |
| **Pend Oreille** | 96 | 98 | 101 | **64.33** | 31 | 34 | 37 |
| **Pierce** | 3,820 | 3,975 | 4,131 | **3,739.67** | 80 | 236 | 391 |
| **San Juan** | 83 | 85 | 87 | **79.00** | 4 | 6 | 8 |
| **Skagit** | 737 | 764 | 790 | **729.00** | 8 | 35 | 61 |
| **Skamania** | 52 | 54 | 56 | **27.00** | 25 | 27 | 29 |
| **Snohomish** | 3,157 | 3,308 | 3,458 | **2,950.87** | 207 | 357 | 507 |
| **Spokane** | 2,643 | 2,728 | 2,813 | **2,671.83** | (29) | 56 | 141 |
| **Stevens** | 269 | 277 | 284 | **150.00** | 119 | 127 | 134 |
| **Thurston** | 1,355 | 1,404 | 1,452 | **1,247.57** | 108 | 156 | 205 |
| **Wahkiakum** | 29 | 30 | 30 | **6.33** | 23 | 23 | 23 |
| **Walla Walla** | 317 | 324 | 332 | **285.00** | 32 | 39 | 47 |
| **Whatcom** | 993 | 1,027 | 1,060 | **1,042.97** | (50) | (16) | 17 |
| **Whitman** | 162 | 167 | 172 | **203.83** | (42) | (37) | (32) |
| **Yakima** | 1,099 | 1,127 | 1,154 | **1,182.67** | (83) | (56) | (29) |

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Signature Hospice Pierce, LLC

Washington State Department of Health

**WAC246-310-290(8)(f) Step 6:**
**Multiply the unmet need from Step 5 by the statewide average length of stay as determined by CMS to determine unmet need patient days in the projection years.**

| | | | | Step 6 (Admits * ALOS) = Unmet Patient Days | | | |
|---|---|---|---|---|---|---|---|
| **County** | **2020 Unmet Need Admissions*** | **2021 Unmet Need Admissions*** | **2022 Unmet Need Admissions*** | **Statewide ALOS** | **2020 Unmet Need Patient Days*** | **2021 Unmet Need Patient Days*** | **2022 Unmet Need Patient Days*** |
| **Adams** | 18 | 19 | 20 | **62.66** | 1,148 | 1,214 | 1,280 |
| **Asotin** | 49 | 53 | 57 | **62.66** | 3,092 | 3,328 | 3,564 |
| **Benton** | (147) | (118) | (90) | **62.66** | (9,222) | (7,421) | (5,620) |
| **Chelan** | 16 | 31 | 46 | **62.66** | 1,000 | 1,932 | 2,864 |
| **Clallam** | 339 | 355 | 371 | **62.66** | 21,238 | 22,228 | 23,217 |
| **Clark** | (310) | (227) | (145) | **62.66** | (19,394) | (14,226) | (9,057) |
| **Columbia** | 24 | 25 | 26 | **62.66** | 1,532 | 1,568 | 1,605 |
| **Cowlitz** | (119) | (100) | (81) | **62.66** | (7,461) | (6,261) | (5,061) |
| **Douglas** | 38 | 44 | 50 | **62.66** | 2,362 | 2,758 | 3,155 |
| **Ferry** | 9 | 10 | 11 | **62.66** | 582 | 631 | 681 |
| **Franklin** | 61 | 71 | 82 | **62.66** | 3,798 | 4,458 | 5,118 |
| **Garfield** | 12 | 13 | 13 | **62.66** | 774 | 788 | 802 |
| **Grant** | 113 | 126 | 140 | **62.66** | 7,055 | 7,911 | 8,766 |
| **Grays Harbor** | 202 | 214 | 226 | **62.66** | 12,688 | 13,418 | 14,147 |
| **Island** | 68 | 80 | 93 | **62.66** | 4,232 | 5,026 | 5,820 |
| **Jefferson** | 41 | 48 | 55 | **62.66** | 2,550 | 2,986 | 3,421 |
| **King** | 63 | 338 | 613 | **62.66** | 3,960 | 21,177 | 38,394 |
| **Kitsap** | (5) | 43 | 91 | **62.66** | (326) | 2,685 | 5,696 |
| **Kittitas** | 13 | 20 | 27 | **62.66** | 846 | 1,268 | 1,690 |
| **Klickitat** | (159) | (156) | (153) | **62.66** | (9,971) | (9,788) | (9,605) |
| **Lewis** | 69 | 82 | 95 | **62.66** | 4,325 | 5,135 | 5,945 |
| **Lincoln** | 39 | 40 | 42 | **62.66** | 2,414 | 2,515 | 2,616 |
| **Mason** | 176 | 191 | 206 | **62.66** | 11,053 | 11,965 | 12,877 |
| **Okanogan** | 81 | 87 | 93 | **62.66** | 5,058 | 5,456 | 5,855 |
| **Pacific** | 83 | 86 | 89 | **62.66** | 5,212 | 5,398 | 5,584 |
| **Pend Oreille** | 31 | 34 | 37 | **62.66** | 1,964 | 2,135 | 2,305 |
| **Pierce** | 80 | 236 | 391 | **62.66** | 5,039 | 14,766 | 24,493 |
| **San Juan** | 4 | 6 | 8 | **62.66** | 232 | 380 | 528 |
| **Skagit** | 8 | 35 | 61 | **62.66** | 520 | 2,183 | 3,847 |
| **Skamania** | 25 | 27 | 29 | **62.66** | 1,557 | 1,685 | 1,813 |
| **Snohomish** | 207 | 357 | 507 | **62.66** | 12,944 | 22,350 | 31,757 |
| **Spokane** | (29) | 56 | 141 | **62.66** | (1,834) | 3,498 | 8,830 |
| **Stevens** | 119 | 127 | 134 | **62.66** | 7,467 | 7,942 | 8,417 |
| **Thurston** | 108 | 156 | 205 | **62.66** | 6,736 | 9,782 | 12,827 |
| **Wahkiakum** | 23 | 23 | 23 | **62.66** | 1,440 | 1,454 | 1,468 |
| **Walla Walla** | 32 | 39 | 47 | **62.66** | 2,016 | 2,473 | 2,930 |
| **Whatcom** | (50) | (16) | 17 | **62.66** | (3,137) | (1,028) | 1,081 |
| **Whitman** | (42) | (37) | (32) | **62.66** | (2,616) | (2,310) | (2,005) |
| **Yakima** | (83) | (56) | (29) | **62.66** | (5,230) | (3,511) | (1,793) |

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Signature Hospice Pierce, LLC

Washington State Department of Health

**WAC246-310-290(8)(g) Step 7:**
**Divide the unmet patient days from Step 6 by 365 to determine the unmet need ADC.**

| | | | | Step 7 (Patient Days / 365) = Unmet ADC | | |
|---|---|---|---|---|---|---|
| **County** | **2020 Unmet Need Patient Days*** | **2021 Unmet Need Patient Days*** | **2022 Unmet Need Patient Days*** | **2020 Unmet Need ADC*** | **2021 Unmet Need ADC*** | **2022 Unmet Need ADC*** |
| **Adams** | 1,148 | 1,214 | 1,280 | 3 | 3 | 4 |
| **Asotin** | 3,092 | 3,328 | 3,564 | 8 | 9 | 10 |
| **Benton** | (9,222) | (7,421) | (5,620) | (25) | (20) | (15) |
| **Chelan** | 1,000 | 1,932 | 2,864 | 3 | 5 | 8 |
| **Clallam** | 21,238 | 22,228 | 23,217 | 58 | 61 | 64 |
| **Clark** | (19,394) | (14,226) | (9,057) | (53) | (39) | (25) |
| **Columbia** | 1,532 | 1,568 | 1,605 | 4 | 4 | 4 |
| **Cowlitz** | (7,461) | (6,261) | (5,061) | (20) | (17) | (14) |
| **Douglas** | 2,362 | 2,758 | 3,155 | 6 | 8 | 9 |
| **Ferry** | 582 | 631 | 681 | 2 | 2 | 2 |
| **Franklin** | 3,798 | 4,458 | 5,118 | 10 | 12 | 14 |
| **Garfield** | 774 | 788 | 802 | 2 | 2 | 2 |
| **Grant** | 7,055 | 7,911 | 8,766 | 19 | 22 | 24 |
| **Grays Harbor** | 12,688 | 13,418 | 14,147 | 35 | 37 | 39 |
| **Island** | 4,232 | 5,026 | 5,820 | 12 | 14 | 16 |
| **Jefferson** | 2,550 | 2,986 | 3,421 | 7 | 8 | 9 |
| **King** | 3,960 | 21,177 | 38,394 | 11 | 58 | 105 |
| **Kitsap** | (326) | 2,685 | 5,696 | (1) | 7 | 16 |
| **Kittitas** | 846 | 1,268 | 1,690 | 2 | 3 | 5 |
| **Klickitat** | (9,971) | (9,788) | (9,605) | (27) | (27) | (26) |
| **Lewis** | 4,325 | 5,135 | 5,945 | 12 | 14 | 16 |
| **Lincoln** | 2,414 | 2,515 | 2,616 | 7 | 7 | 7 |
| **Mason** | 11,053 | 11,965 | 12,877 | 30 | 33 | 35 |
| **Okanogan** | 5,058 | 5,456 | 5,855 | 14 | 15 | 16 |
| **Pacific** | 5,212 | 5,398 | 5,584 | 14 | 15 | 15 |
| **Pend Oreille** | 1,964 | 2,135 | 2,305 | 5 | 6 | 6 |
| **Pierce** | 5,039 | 14,766 | 24,493 | 14 | 40 | 67 |
| **San Juan** | 232 | 380 | 528 | 1 | 1 | 1 |
| **Skagit** | 520 | 2,183 | 3,847 | 1 | 6 | 11 |
| **Skamania** | 1,557 | 1,685 | 1,813 | 4 | 5 | 5 |
| **Snohomish** | 12,944 | 22,350 | 31,757 | 35 | 61 | 87 |
| **Spokane** | (1,834) | 3,498 | 8,830 | (5) | 10 | 24 |
| **Stevens** | 7,467 | 7,942 | 8,417 | 20 | 22 | 23 |
| **Thurston** | 6,736 | 9,782 | 12,827 | 18 | 27 | 35 |
| **Wahkiakum** | 1,440 | 1,454 | 1,468 | 4 | 4 | 4 |
| **Walla Walla** | 2,016 | 2,473 | 2,930 | 6 | 7 | 8 |
| **Whatcom** | (3,137) | (1,028) | 1,081 | (9) | (3) | 3 |
| **Whitman** | (2,616) | (2,310) | (2,005) | (7) | (6) | (5) |
| **Yakima** | (5,230) | (3,511) | (1,793) | (14) | (10) | (5) |

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Posted October 30, 2020*

Signature Hospice Pierce, LLC

Washington State Department of Health

**WAC246-310-290(8)(h) Step 8:**
**Determine the number of hospice agencies in the planning area that could support the unmet need with an ADC of thirty-five.**

**Application Year**

| Step 7 (Patient Days / 365) = Unmet ADC | | | | Step 8 - Numeric Need | |
|---|---|---|---|---|---|
| **County** | **2020 Unmet Need ADC*** | **2021 Unmet Need ADC*** | **2022 Unmet Need ADC*** | **Numeric Need?** | **Number of New Agencies Needed?**** |
| **Adams** | 3 | 3 | 4 | FALSE | FALSE |
| **Asotin** | 8 | 9 | 10 | FALSE | FALSE |
| **Benton** | (25) | (20) | (15) | FALSE | FALSE |
| **Chelan** | 3 | 5 | 8 | FALSE | FALSE |
| **Clallam** | 58 | 61 | 64 | ***TRUE*** | ***1*** |
| **Clark** | (53) | (39) | (25) | FALSE | FALSE |
| **Columbia** | 4 | 4 | 4 | FALSE | FALSE |
| **Cowlitz** | (20) | (17) | (14) | FALSE | FALSE |
| **Douglas** | 6 | 8 | 9 | FALSE | FALSE |
| **Ferry** | 2 | 2 | 2 | FALSE | FALSE |
| **Franklin** | 10 | 12 | 14 | FALSE | FALSE |
| **Garfield** | 2 | 2 | 2 | FALSE | FALSE |
| **Grant** | 19 | 22 | 24 | FALSE | FALSE |
| **Grays Harbor** | 35 | 37 | 39 | ***TRUE*** | ***1*** |
| **Island** | 12 | 14 | 16 | FALSE | FALSE |
| **Jefferson** | 7 | 8 | 9 | FALSE | FALSE |
| **King** | 11 | 58 | 105 | ***TRUE*** | ***3*** |
| **Kitsap** | (1) | 7 | 16 | FALSE | FALSE |
| **Kittitas** | 2 | 3 | 5 | FALSE | FALSE |
| **Klickitat** | (27) | (27) | (26) | FALSE | FALSE |
| **Lewis** | 12 | 14 | 16 | FALSE | FALSE |
| **Lincoln** | 7 | 7 | 7 | FALSE | FALSE |
| **Mason** | 30 | 33 | 35 | ***TRUE*** | ***1*** |
| **Okanogan** | 14 | 15 | 16 | FALSE | FALSE |
| **Pacific** | 14 | 15 | 15 | FALSE | FALSE |
| **Pend Oreille** | 5 | 6 | 6 | FALSE | FALSE |
| **Pierce** | 14 | 40 | 67 | ***TRUE*** | ***1*** |
| **San Juan** | 1 | 1 | 1 | FALSE | FALSE |
| **Skagit** | 1 | 6 | 11 | FALSE | FALSE |
| **Skamania** | 4 | 5 | 5 | FALSE | FALSE |
| **Snohomish** | 35 | 61 | 87 | ***TRUE*** | ***2*** |
| **Spokane** | (5) | 10 | 24 | FALSE | FALSE |
| **Stevens** | 20 | 22 | 23 | FALSE | FALSE |
| **Thurston** | 18 | 27 | 35 | ***TRUE*** | ***1*** |
| **Wahkiakum** | 4 | 4 | 4 | FALSE | FALSE |
| **Walla Walla** | 6 | 7 | 8 | FALSE | FALSE |
| **Whatcom** | (9) | (3) | 3 | FALSE | FALSE |
| **Whitman** | (7) | (6) | (5) | FALSE | FALSE |
| **Yakima** | (14) | (10) | (5) | FALSE | FALSE |

*a negative number indicates existing hospice service capacity exceeds the projected utilization based on the statewide use rate.

**The numeric need methodology projects need for whole hospice agencies only - not partial hospice agencies. Therefore, the results are rounded down to the nearest whole number.

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*0-64 Population Projection*

Signature Hospice Pierce, LLC

| County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2017-2019 Average Population |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adams | 17,637 | 17,768 | 17,899 | 18,029 | 18,160 | 18,291 | 18,456 | 18,622 | 18,787 | 18,953 | 19,118 | 18,029 |
| Asotin | 16,969 | 16,906 | 16,842 | 16,779 | 16,715 | 16,652 | 16,596 | 16,540 | 16,485 | 16,429 | 16,373 | 16,779 |
| Benton | 162,262 | 163,693 | 165,123 | 166,554 | 167,984 | 169,415 | 171,026 | 172,638 | 174,249 | 175,861 | 177,472 | 166,554 |
| Chelan | 61,284 | 61,520 | 61,755 | 61,991 | 62,227 | 62,463 | 62,512 | 62,562 | 62,611 | 62,661 | 62,710 | 61,991 |
| Clallam | 52,716 | 52,661 | 52,605 | 52,550 | 52,494 | 52,439 | 52,233 | 52,027 | 51,821 | 51,615 | 51,409 | 52,550 |
| Clark | 387,296 | 393,291 | 399,287 | 405,282 | 411,278 | 417,273 | 421,901 | 426,529 | 431,158 | 435,786 | 440,414 | 405,282 |
| Columbia | 2,988 | 2,947 | 2,905 | 2,863 | 2,822 | 2,780 | 2,745 | 2,710 | 2,675 | 2,640 | 2,605 | 2,863 |
| Cowlitz | 85,417 | 85,517 | 85,617 | 85,717 | 85,817 | 85,917 | 85,843 | 85,769 | 85,695 | 85,621 | 85,547 | 85,717 |
| Douglas | 33,540 | 33,938 | 34,335 | 34,732 | 35,130 | 35,527 | 35,803 | 36,080 | 36,356 | 36,633 | 36,909 | 34,732 |
| Ferry | 5,834 | 5,782 | 5,731 | 5,680 | 5,628 | 5,577 | 5,541 | 5,506 | 5,470 | 5,435 | 5,399 | 5,680 |
| Franklin | 79,651 | 81,742 | 83,832 | 85,922 | 88,012 | 90,102 | 92,443 | 94,784 | 97,124 | 99,465 | 101,806 | 85,922 |
| Garfield | 1,665 | 1,644 | 1,623 | 1,602 | 1,581 | 1,560 | 1,541 | 1,522 | 1,502 | 1,483 | 1,464 | 1,602 |
| Grant | 81,535 | 82,660 | 83,784 | 84,909 | 86,033 | 87,158 | 88,240 | 89,322 | 90,403 | 91,485 | 92,567 | 84,909 |
| Grays Harbor | 59,105 | 58,675 | 58,246 | 57,817 | 57,387 | 56,958 | 56,679 | 56,401 | 56,122 | 55,844 | 55,565 | 57,817 |
| Island | 62,514 | 62,664 | 62,814 | 62,964 | 63,114 | 63,264 | 63,280 | 63,296 | 63,312 | 63,328 | 63,344 | 62,964 |
| Jefferson | 20,636 | 20,653 | 20,670 | 20,688 | 20,705 | 20,722 | 20,636 | 20,550 | 20,463 | 20,377 | 20,291 | 20,688 |
| King | 1,798,581 | 1,820,215 | 1,841,848 | 1,863,482 | 1,885,115 | 1,906,749 | 1,918,470 | 1,930,192 | 1,941,913 | 1,953,635 | 1,965,356 | 1,863,482 |
| Kitsap | 212,548 | 214,045 | 215,543 | 217,040 | 218,538 | 220,035 | 220,614 | 221,192 | 221,771 | 222,349 | 222,928 | 217,040 |
| Kittitas | 36,206 | 36,768 | 37,330 | 37,892 | 38,453 | 39,015 | 39,286 | 39,556 | 39,827 | 40,097 | 40,368 | 37,892 |
| Klickitat | 16,208 | 16,082 | 15,955 | 15,828 | 15,702 | 15,575 | 15,439 | 15,304 | 15,168 | 15,033 | 14,897 | 15,828 |
| Lewis | 61,494 | 61,796 | 62,097 | 62,398 | 62,700 | 63,001 | 63,164 | 63,327 | 63,491 | 63,654 | 63,817 | 62,398 |
| Lincoln | 8,101 | 8,042 | 7,982 | 7,923 | 7,864 | 7,805 | 7,751 | 7,698 | 7,644 | 7,591 | 7,537 | 7,923 |
| Mason | 48,672 | 49,162 | 49,652 | 50,142 | 50,632 | 51,122 | 51,397 | 51,672 | 51,946 | 52,221 | 52,496 | 50,142 |
| Okanogan | 33,087 | 32,906 | 32,726 | 32,545 | 32,364 | 32,183 | 32,087 | 31,991 | 31,896 | 31,800 | 31,704 | 32,545 |
| Pacific | 15,115 | 14,972 | 14,830 | 14,688 | 14,545 | 14,403 | 14,322 | 14,242 | 14,161 | 14,081 | 14,000 | 14,688 |
| Pend Oreille | 10,045 | 9,998 | 9,952 | 9,905 | 9,859 | 9,812 | 9,769 | 9,727 | 9,684 | 9,642 | 9,599 | 9,905 |
| Pierce | 721,137 | 729,937 | 738,738 | 747,538 | 756,339 | 765,139 | 769,918 | 774,696 | 779,475 | 784,253 | 789,032 | 747,538 |
| San Juan | 11,305 | 11,194 | 11,084 | 10,974 | 10,863 | 10,753 | 10,730 | 10,707 | 10,684 | 10,661 | 10,638 | 10,974 |
| Skagit | 97,885 | 98,616 | 99,346 | 100,076 | 100,807 | 101,537 | 101,887 | 102,236 | 102,586 | 102,935 | 103,285 | 100,076 |
| Skamania | 9,272 | 9,266 | 9,260 | 9,254 | 9,248 | 9,242 | 9,223 | 9,205 | 9,186 | 9,168 | 9,149 | 9,254 |
| Snohomish | 661,812 | 672,806 | 683,800 | 694,793 | 705,787 | 716,781 | 721,527 | 726,273 | 731,019 | 735,765 | 740,511 | 694,793 |
| Spokane | 414,493 | 416,684 | 418,875 | 421,066 | 423,256 | 425,447 | 426,740 | 428,033 | 429,326 | 430,619 | 431,912 | 421,066 |
| Stevens | 34,576 | 34,459 | 34,343 | 34,226 | 34,109 | 33,992 | 33,917 | 33,841 | 33,766 | 33,690 | 33,615 | 34,226 |
| Thurston | 224,951 | 228,261 | 231,571 | 234,880 | 238,190 | 241,500 | 243,867 | 246,235 | 248,602 | 250,970 | 253,337 | 234,880 |
| Wahkiakum | 2,726 | 2,669 | 2,612 | 2,555 | 2,498 | 2,441 | 2,405 | 2,368 | 2,332 | 2,295 | 2,259 | 2,555 |
| Walla Walla | 49,893 | 50,111 | 50,328 | 50,546 | 50,763 | 50,981 | 51,028 | 51,075 | 51,121 | 51,168 | 51,215 | 50,546 |
| Whatcom | 175,840 | 178,234 | 180,629 | 183,023 | 185,418 | 187,812 | 189,267 | 190,722 | 192,178 | 193,633 | 195,088 | 183,023 |
| Whitman | 42,880 | 42,965 | 43,051 | 43,137 | 43,222 | 43,308 | 43,315 | 43,322 | 43,330 | 43,337 | 43,344 | 43,137 |
| Yakima | 215,882 | 217,605 | 219,328 | 221,051 | 222,774 | 224,497 | 225,822 | 227,147 | 228,473 | 229,798 | 231,123 | 221,051 |

**Source:**
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*65+ Population Projection*

Signature Hospice Pierce, LLC

| County | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 | 2017-2019 Average Population |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Adams | 1,773 | 1,887 | 2,000 | 2,114 | 2,227 | 2,341 | 2,383 | 2,424 | 2,466 | 2,507 | 2,549 | 2,114 |
| Asotin | 5,041 | 5,233 | 5,426 | 5,619 | 5,812 | 6,005 | 6,175 | 6,344 | 6,514 | 6,683 | 6,853 | 5,619 |
| Benton | 26,328 | 27,492 | 28,657 | 29,821 | 30,986 | 32,150 | 33,373 | 34,597 | 35,820 | 37,044 | 38,267 | 29,821 |
| Chelan | 13,746 | 14,279 | 14,811 | 15,343 | 15,876 | 16,408 | 17,052 | 17,695 | 18,339 | 18,982 | 19,626 | 15,343 |
| Clallam | 19,934 | 20,401 | 20,867 | 21,334 | 21,800 | 22,267 | 22,901 | 23,535 | 24,168 | 24,802 | 25,436 | 21,334 |
| Clark | 64,524 | 68,044 | 71,564 | 75,085 | 78,605 | 82,125 | 85,686 | 89,247 | 92,807 | 96,368 | 99,929 | 75,085 |
| Columbia | 1,102 | 1,135 | 1,169 | 1,202 | 1,236 | 1,269 | 1,287 | 1,304 | 1,322 | 1,339 | 1,357 | 1,202 |
| Cowlitz | 18,863 | 19,684 | 20,505 | 21,326 | 22,148 | 22,969 | 23,719 | 24,470 | 25,220 | 25,971 | 26,721 | 21,326 |
| Douglas | 6,450 | 6,831 | 7,213 | 7,595 | 7,976 | 8,358 | 8,666 | 8,974 | 9,283 | 9,591 | 9,899 | 7,595 |
| Ferry | 1,876 | 1,949 | 2,022 | 2,095 | 2,168 | 2,241 | 2,289 | 2,337 | 2,386 | 2,434 | 2,482 | 2,095 |
| Franklin | 7,499 | 7,921 | 8,343 | 8,765 | 9,188 | 9,610 | 10,083 | 10,557 | 11,030 | 11,504 | 11,977 | 8,765 |
| Garfield | 595 | 607 | 620 | 633 | 645 | 658 | 669 | 680 | 692 | 703 | 714 | 633 |
| Grant | 12,395 | 13,011 | 13,628 | 14,244 | 14,861 | 15,477 | 16,071 | 16,665 | 17,258 | 17,852 | 18,446 | 14,244 |
| Grays Harbor | 14,005 | 14,535 | 15,064 | 15,594 | 16,123 | 16,653 | 17,133 | 17,612 | 18,092 | 18,571 | 19,051 | 15,594 |
| Island | 18,086 | 18,625 | 19,163 | 19,701 | 20,239 | 20,777 | 21,412 | 22,047 | 22,682 | 23,317 | 23,952 | 19,701 |
| Jefferson | 10,244 | 10,580 | 10,916 | 11,252 | 11,588 | 11,924 | 12,323 | 12,722 | 13,121 | 13,520 | 13,919 | 11,252 |
| King | 254,219 | 268,307 | 282,395 | 296,484 | 310,572 | 324,660 | 337,771 | 350,881 | 363,992 | 377,102 | 390,213 | 296,484 |
| Kitsap | 45,652 | 47,697 | 49,743 | 51,788 | 53,833 | 55,878 | 58,185 | 60,492 | 62,800 | 65,107 | 67,414 | 51,788 |
| Kittitas | 6,464 | 6,760 | 7,055 | 7,351 | 7,647 | 7,943 | 8,266 | 8,589 | 8,911 | 9,234 | 9,557 | 7,351 |
| Klickitat | 4,792 | 5,051 | 5,310 | 5,570 | 5,829 | 6,088 | 6,268 | 6,448 | 6,627 | 6,807 | 6,987 | 5,570 |
| Lewis | 15,166 | 15,576 | 15,987 | 16,398 | 16,808 | 17,219 | 17,697 | 18,175 | 18,652 | 19,130 | 19,608 | 16,398 |
| Lincoln | 2,619 | 2,687 | 2,755 | 2,823 | 2,891 | 2,959 | 3,039 | 3,119 | 3,200 | 3,280 | 3,360 | 2,823 |
| Mason | 13,528 | 14,123 | 14,717 | 15,311 | 15,905 | 16,499 | 17,167 | 17,836 | 18,504 | 19,173 | 19,841 | 15,311 |
| Okanogan | 8,773 | 9,198 | 9,624 | 10,050 | 10,475 | 10,901 | 11,210 | 11,519 | 11,827 | 12,136 | 12,445 | 10,050 |
| Pacific | 6,095 | 6,258 | 6,421 | 6,584 | 6,747 | 6,910 | 7,035 | 7,159 | 7,284 | 7,408 | 7,533 | 6,584 |
| Pend Oreille | 3,195 | 3,378 | 3,560 | 3,742 | 3,925 | 4,107 | 4,239 | 4,371 | 4,504 | 4,636 | 4,768 | 3,742 |
| Pierce | 108,983 | 114,409 | 119,836 | 125,262 | 130,688 | 136,114 | 142,422 | 148,729 | 155,037 | 161,344 | 167,652 | 125,262 |
| San Juan | 4,876 | 5,099 | 5,322 | 5,545 | 5,768 | 5,991 | 6,174 | 6,357 | 6,541 | 6,724 | 6,907 | 5,545 |
| Skagit | 22,735 | 24,021 | 25,308 | 26,595 | 27,881 | 29,168 | 30,314 | 31,460 | 32,607 | 33,753 | 34,899 | 26,595 |
| Skamania | 2,158 | 2,286 | 2,414 | 2,542 | 2,670 | 2,798 | 2,923 | 3,048 | 3,172 | 3,297 | 3,422 | 2,542 |
| Snohomish | 95,788 | 101,674 | 107,560 | 113,447 | 119,333 | 125,219 | 131,978 | 138,737 | 145,495 | 152,254 | 159,013 | 113,447 |
| Spokane | 73,817 | 77,325 | 80,834 | 84,343 | 87,852 | 91,361 | 94,670 | 97,979 | 101,288 | 104,597 | 107,906 | 84,343 |
| Stevens | 9,454 | 9,930 | 10,407 | 10,884 | 11,360 | 11,837 | 12,214 | 12,591 | 12,969 | 13,346 | 13,723 | 10,884 |
| Thurston | 42,459 | 44,534 | 46,608 | 48,683 | 50,757 | 52,832 | 54,900 | 56,967 | 59,035 | 61,102 | 63,170 | 48,683 |
| Wahkiakum | 1,254 | 1,316 | 1,379 | 1,441 | 1,503 | 1,565 | 1,580 | 1,595 | 1,611 | 1,626 | 1,641 | 1,441 |
| Walla Walla | 10,757 | 10,819 | 10,881 | 10,944 | 11,006 | 11,068 | 11,350 | 11,632 | 11,915 | 12,197 | 12,479 | 10,944 |
| Whatcom | 33,950 | 35,688 | 37,426 | 39,164 | 40,902 | 42,640 | 44,217 | 45,794 | 47,372 | 48,949 | 50,526 | 39,164 |
| Whitman | 4,370 | 4,659 | 4,948 | 5,237 | 5,526 | 5,815 | 6,008 | 6,201 | 6,395 | 6,588 | 6,781 | 5,237 |
| Yakima | 34,088 | 34,949 | 35,809 | 36,670 | 37,530 | 38,391 | 39,475 | 40,559 | 41,643 | 42,727 | 43,811 | 36,670 |

**Source:**
2017 OFM Population Projections, Medium-Series
Prepared by DOH Program Staff

# Department of Health
## 2020-2021 Hospice Numeric Need Methodology
*Preliminary Death Data Updated October 12, 2020*

| | 0-64 | | | 65+ | | |
|---|---|---|---|---|---|---|
| **County** | **2017** | **2018** | **2019** | **2017** | **2018** | **2019** |
| ADAMS | 38 | 28 | 35 | 78 | 72 | 93 |
| ASOTIN | 49 | 52 | 54 | 190 | 214 | 222 |
| BENTON | 385 | 331 | 346 | 1,081 | 1,125 | 1,154 |
| CHELAN | 124 | 130 | 137 | 556 | 573 | 626 |
| CLALLAM | 180 | 191 | 186 | 842 | 871 | 955 |
| CLARK | 883 | 874 | 887 | 2,579 | 2,767 | 2,987 |
| COLUMBIA | 19 | 6 | 7 | 116 | 43 | 52 |
| COWLITZ | 351 | 300 | 294 | 917 | 840 | 951 |
| DOUGLAS | 71 | 51 | 63 | 232 | 255 | 270 |
| FERRY | 30 | 28 | 20 | 60 | 55 | 64 |
| FRANKLIN | 133 | 145 | 123 | 284 | 278 | 313 |
| GARFIELD | 6 | 5 | 5 | 17 | 30 | 21 |
| GRANT | 203 | 195 | 197 | 509 | 524 | 508 |
| GRAYS HARBOR | 238 | 227 | 251 | 622 | 647 | 659 |
| ISLAND | 166 | 135 | 167 | 630 | 675 | 642 |
| JEFFERSON | 69 | 64 | 72 | 308 | 336 | 338 |
| KING | 3,256 | 3,264 | 3,275 | 10,039 | 9,917 | 10,213 |
| KITSAP | 485 | 515 | 557 | 1,780 | 1,713 | 1,811 |
| KITTITAS | 91 | 68 | 90 | 237 | 239 | 266 |
| KLICKITAT | 63 | 58 | 46 | 151 | 158 | 160 |
| LEWIS | 210 | 227 | 210 | 721 | 730 | 722 |
| LINCOLN | 20 | 25 | 25 | 105 | 94 | 89 |
| MASON | 169 | 158 | 167 | 550 | 526 | 548 |
| OKANOGAN | 119 | 103 | 119 | 350 | 332 | 358 |
| PACIFIC | 88 | 64 | 66 | 262 | 279 | 265 |
| PEND OREILLE | 34 | 43 | 31 | 133 | 130 | 125 |
| PIERCE | 1,936 | 1,964 | 1,911 | 5,019 | 4,926 | 5,002 |
| SAN JUAN | 18 | 19 | 20 | 115 | 114 | 127 |
| SKAGIT | 271 | 231 | 229 | 1,007 | 1,001 | 1,018 |
| SKAMANIA | 16 | 27 | 19 | 65 | 56 | 87 |
| SNOHOMISH | 1,483 | 1,533 | 1,533 | 4,118 | 4,055 | 4,081 |
| SPOKANE | 1,147 | 1,177 | 1,143 | 3,527 | 3,556 | 3,545 |
| STEVENS | 96 | 113 | 112 | 376 | 373 | 345 |
| THURSTON | 530 | 554 | 525 | 1,768 | 1,823 | 1,908 |
| WAHKIAKUM | 3 | 13 | 11 | 37 | 33 | 53 |
| WALLA WALLA | 123 | 110 | 118 | 501 | 445 | 450 |
| WHATCOM | 367 | 360 | 394 | 1,329 | 1,252 | 1,461 |
| WHITMAN | 57 | 66 | 47 | 236 | 199 | 219 |
| YAKIMA | 586 | 601 | 555 | 1,471 | 1,517 | 1,451 |



**Source:**
Vital Statistics Death Data for Years 2017-2019
Prepared by DOH Program Staff

**Department of Health**
**2020-2021 Hospice Numeric Need Methodology**
*Survey Responses*

Signature Hospice Pierce, LLC

Note: Kindred Hospice in Whitman and Spokane Counties did not respond to the department's survey for 2018 data. As a result, the averageof 2016 and 2017 data was used as a proxy for 2018.

| Agency Name | License Number | County | Year | 0-64 | 65+ |
|---|---|---|---|---|---|
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Adams | 2017 | 4 | 30 |
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Grant | 2017 | 44 | 209 |
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Lincoln | 2017 | 3 | 22 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Clallam | 2017 | 14 | 143 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Jefferson | 2017 | 1 | 14 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Lewis | 2017 | 17 | 257 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Mason | 2017 | 8 | 43 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Thurston | 2017 | 39 | 235 |
| Astria Home Health and Hospice (Yakima Regional Home Health and Hospice) | IHS.FS.60097245 | Yakima | 2017 | 11 | 48 |
| Central Washington Hospital Home Care Services | IHS.FS.00000250 | Chelan | 2017 | 44 | 319 |
| Central Washington Hospital Home Care Services | IHS.FS.00000250 | Douglas | 2017 | 18 | 119 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Clark | 2017 | 67 | 419 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Cowlitz | 2017 | 116 | 630 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Wahkiakum | 2017 | 1 | 4 |
| Elite Home Health and Hospice | IHS.FS.60384078 | Asotin | 2017 | 7 | 85 |
| Elite Home Health and Hospice | IHS.FS.60384078 | Garfield | 2017 | 1 | 1 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | Island | 2017 | 0 | 7 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | King | 2017 | 272 | 2393 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | Snohomish | 2017 | 82 | 478 |
| Franciscan Hospice | IHS.FS.00000287 | King | 2017 | 90 | 1115 |
| Franciscan Hospice | IHS.FS.00000287 | Kitsap | 2017 | 64 | 796 |
| Franciscan Hospice | IHS.FS.00000287 | Pierce | 2017 | 181 | 2242 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Douglas | 2017 | 1 | 10 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Grant | 2017 | 0 | 7 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Okanogan | 2017 | 34 | 132 |
| Gentiva Hospice (Odyssey Hospice) | IHS.FS.60330209 | King | 2017 | 14 | 375 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Grays Harbor | 2017 | 72 | 292 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Pacific | 2017 | 17 | 106 |
| Heart of Hospice | IHS.FS.00000185 | Skamania | 2017 | 2 | 11 |
| Heart of Hospice | IHS.FS.00000185 | Klickitat | 2017 | 1 | 20 |
| Heartlinks Hospice and Palliative Care (Lower Valley Hospice) | IHS.FS.00000369 | Benton | 2017 | 12 | 130 |
| Heartlinks Hospice and Palliative Care (Lower Valley Hospice) | IHS.FS.00000369 | Yakima | 2017 | 28 | 197 |
| Home Health Care of Whidbey General Hospital (Whidbey General) | IHS.FS.00000323 | Island | 2017 | 21 | 248 |
| PeaceHealth Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Clark | 2017 | 165 | 1064 |
| PeaceHealth Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Cowlitz | 2017 | 7 | 47 |
| PeaceHealth Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Skamania | 2017 | 0 | 0 |
| Horizon Hospice | IHS.FS.00000332 | Spokane | 2017 | 35 | 420 |
| Hospice of Kitsap County | IHS.FS.00000335 | Kitsap | 2017 | 0 | 0 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2017 | 7 | 37 |
| Hospice of Spokane | IHS.FS.00000337 | Lincoln | 2017 | 0 | 0 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2017 | 8 | 55 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2017 | 340 | 1722 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2017 | 25 | 128 |
| Hospice of Spokane | IHS.FS.00000337 | Whitman | 2017 | 0 | 1 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Island | 2017 | 11 | 77 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | San Juan | 2017 | 3 | 70 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Skagit | 2017 | 61 | 616 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Snohomish | 2017 | 7 | 83 |
| Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County) | IHS.FS.00000349 | Jefferson | 2017 | 13 | 153 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Clark | 2017 | 50 | 415 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Cowlitz | 2017 | 1 | 18 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Skamania | 2017 | 0 | 0 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | King | 2017 | 38 | 487 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Kitsap | 2017 | 7 | 107 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Pierce | 2017 | 27 | 189 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Snohomish | 2017 | 2 | 68 |
| Kindred Hospice (Gentiva Hospice | IHS.FS.60308060 | Spokane | 2017 | 22 | 325 |
| Kindred Hospice (Gentiva Hospice | IHS.FS.60308060 | Whitman | 2017 | 29 | 247 |
| Kittitas Valley Home Health and Hospice | IHS.FS.00000320 | Kittitas | 2017 | 46 | 134 |
| Klickitat Valley Home Health & Hospice (Klickitat Valley Health) | IHS.FS.00000361 | Klickitat | 2017 | 11 | 33 |
| Kline Galland Community Based Services | IHS.FS.60103742 | King | 2017 | 13 | 301 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2017 | 149 | 717 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639376 | King | 2017 | 42 | 149 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639377 | Kitsap | 2017 | 33 | 253 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639378 | Pierce | 2017 | 211 | 925 |
| Providence Hospice (Hospice of the Gorge) | IHS.FS.60201476 | Klickitat | 2017 | 5 | 29 |
| Providence Hospice (Hospice of the Gorge) | IHS.FS.60201476 | Skamania | 2017 | 2 | 10 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Island | 2017 | 3 | 32 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | King | 2017 | 5 | 14 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Snohomish | 2017 | 238 | 1440 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2017 | 387 | 1888 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Snohomish | 2017 | 10 | 15 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Lewis | 2017 | 28 | 163 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Mason | 2017 | 26 | 189 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Thurston | 2017 | 105 | 664 |
| Tri-Cities Chaplaincy | IHS.FS.00000456 | Benton | 2017 | 98 | 745 |
| Tri-Cities Chaplaincy | IHS.FS.00000456 | Franklin | 2017 | 15 | 122 |



**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Prepared by DOH Program Staff

| | | | | | |
|---|---|---|---|---|---|
| Walla Walla Community Hospice | IHS.FS.60480441 | Columbia | 2017 | 1 | 17 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Walla Walla | 2017 | 45 | 276 |
| Wesley Homes | IHS.FS.60276500 | King | 2017 | 1 | 17 |
| Whatcom Hospice (Peacehealth) | IHS.FS.00000471 | Whatcom | 2017 | 139 | 766 |
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Adams | 2018 | 6 | 34 |
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Grant | 2018 | 40 | 254 |
| Assured Home Health and Hospice (Central Basin/Assured Hospice) | IHS.FS.60092413 | Lincoln | 2018 | 6 | 28 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Clallam | 2018 | 16 | 186 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Jefferson | 2018 | 1 | 11 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Lewis | 2018 | 35 | 280 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Mason | 2018 | 4 | 44 |
| Assured Home Health, Hospice & Home Care | IHS.FS.00000229 | Thurston | 2018 | 24 | 273 |
| Astria Home Health and Hospice (Yakima Regional Home Health and Hospice) | IHS.FS.60097245 | Yakima | 2018 | 41 | 8 |
| Central Washington Hospital Home Care Services | IHS.FS.00000250 | Chelan | 2018 | 34 | 386 |
| Central Washington Hospital Home Care Services | IHS.FS.00000250 | Douglas | 2018 | 10 | 133 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Clark | 2018 | 54 | 383 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Cowlitz | 2018 | 87 | 524 |
| Community Home Health and Hospice CHHH Community Home Care Hospice | IHS.FS.00000262 | Wahkiakum | 2018 | 2 | 5 |
| Elite Home Health and Hospice | IHS.FS.60384078 | Asotin | 2018 | 6 | 121 |
| Elite Home Health and Hospice | IHS.FS.60384078 | Garfield | 2018 | 1 | 2 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | Island | 2018 | 1 | 9 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | King | 2018 | 348 | 1989 |
| Evergreen Health Home Care Services | IHS.FS.00000278 | Snohomish | 2018 | 79 | 690 |
| Franciscan Hospice | IHS.FS.00000287 | King | 2018 | 102 | 921 |
| Franciscan Hospice | IHS.FS.00000287 | Kitsap | 2018 | 141 | 693 |
| Franciscan Hospice | IHS.FS.00000287 | Pierce | 2018 | 331 | 2110 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Douglas | 2018 | 0 | 3 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Grant | 2018 | 1 | 7 |
| Frontier Home Health and Hospice (Okanogan Regional) | IHS.FS.60379608 | Okanogan | 2018 | 21 | 148 |
| Gentiva Hospice (Odyssey Hospice) | IHS.FS.60330209 | King | 2018 | 37 | 180 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Grays Harbor | 2018 | 35 | 180 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Pacific | 2018 | 13 | 71 |
| Heart of Hospice | IHS.FS.00000185 | Skamania | 2018 | 0 | 10 |
| Heart of Hospice | IHS.FS.00000185 | Klickitat | 2018 | 1 | 23 |
| Heartlinks Hospice and Palliative Care (Lower Valley Hospice) | IHS.FS.00000369 | Benton | 2018 | 6 | 137 |
| Heartlinks Hospice and Palliative Care (Lower Valley Hospice) | IHS.FS.00000369 | Yakima | 2018 | 24 | 219 |
| Home Health Care of Whidbey General Hospital (Whidbey General) | IHS.FS.00000323 | Island | 2018 | 20 | 235 |
| Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Clark | 2018 | 243 | 1305 |
| Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Cowlitz | 2018 | 20 | 76 |
| Homecare and Hospice Southwest (Hospice SW) | IHS.FS.60331226 | Skamania | 2018 | 1 | 1 |
| Horizon Hospice | IHS.FS.00000332 | Spokane | 2018 | 31 | 389 |
| Hospice of Kitsap County | IHS.FS.00000335 | Kitsap | 2018 | 0 | 0 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2018 | 6 | 29 |
| Hospice of Spokane | IHS.FS.00000337 | Lincoln | 2018 | 1 | 1 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2018 | 8 | 53 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2018 | 346 | 1593 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2018 | 30 | 121 |
| Hospice of Spokane | IHS.FS.00000337 | Whitman | 2018 | none reported | none reported |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Island | 2018 | 6 | 60 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | San Juan | 2018 | 6 | 79 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Skagit | 2018 | 48 | 680 |
| Hospice of the Northwest (Skagit Hospice Service) | IHS.FS.00000437 | Snohomish | 2018 | 2 | 67 |
| Jefferson Healthcare Home Health and Hospice (Hospice of Jefferson County) | IHS.FS.00000349 | Jefferson | 2018 | 20 | 144 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Clark | 2018 | 39 | 436 |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Cowlitz | 2018 | none reported | none reported |
| Kaiser Permanente Continuing Care Services | IHS.FS.00000353 | Skamania | 2018 | none reported | none reported |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | King | 2018 | 25 | 416 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Kitsap | 2018 | 14 | 96 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Pierce | 2018 | 35 | 198 |
| Kaiser Permanente Home Health and Hospice (Group Health) | IHS.FS.00000305 | Snohomish | 2018 | 14 | 94 |
| Kindred Hospice (Gentiva Hospice | IHS.FS.60308060 | Spokane | 2018 | 23 | 265.5 |
| Kindred Hospice (Gentiva Hospice | IHS.FS.60308060 | Whitman | 2018 | 19 | 226.5 |
| Kittitas Valley Home Health and Hospice | IHS.FS.00000320 | Kittitas | 2018 | 15 | 135 |
| Klickitat Valley Home Health & Hospice (Klickitat Valley Health) | IHS.FS.00000361 | Klickitat | 2018 | 5 | 40 |
| Kline Galland Community Based Services | IHS.FS.60103742 | King | 2018 | 29 | 368 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2018 | 183 | 750 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639376 | King | 2018 | 32 | 158 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639377 | Kitsap | 2018 | 25 | 232 |
| MultiCare Home Health, Hospice and Palliative Care | IHS.FS.60639378 | Pierce | 2018 | 177 | 867 |
| Providence Hospice (Hospice of the Gorge) | IHS.FS.60201476 | Klickitat | 2018 | 4 | 18 |
| Providence Hospice (Hospice of the Gorge) | IHS.FS.60201476 | Skamania | 2018 | 1 | 9 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Island | 2018 | 11 | 44 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | King | 2018 | none reported | none reported |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Snohomish | 2018 | 316 | 1772 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2018 | 407 | 1959 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Snohomish | 2018 | 11 | 13 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Lewis | 2018 | 21 | 140 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Mason | 2018 | 10 | 117 |
| Providence SoundHomeCare and Hospice | IHS.FS.00000420 | Thurston | 2018 | 90 | 663 |
| Tri-Cities Chaplaincy | IHS.FS.00000456 | Benton | 2018 | 112 | 750 |
| Tri-Cities Chaplaincy | IHS.FS.00000456 | Franklin | 2018 | 30 | 155 |

| | | | | | |
|---|---|---|---|---|---|
| Walla Walla Community Hospice | IHS.FS.60480441 | Columbia | 2018 | 1 | 23 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Walla Walla | 2018 | 24 | 227 |
| Wesley Homes | IHS.FS.60276500 | King | 2018 | 29 | 368 |
| Whatcom Hospice (Peacehealth) | IHS.FS.00000471 | Whatcom | 2018 | 117 | 770 |
| IRREGULAR-COMMUNITY HOME HEALTH & HOSPICE | IHS.FS.00000262 | Pacific | 2018 | 0 | 1 |
| IRREGULAR-MULTICARE | IHS.FS.60639376 | Clallam | 2018 | 0 | 1 |
| Alpha Home Health | IHS.FS.61032013 | Snohomish | 2019 | 0 | 0 |
| Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice | IHS.FS.60384078 | Asotin | 2019 | 9 | 71 |
| Alpowa Healthcare Inc. d/b/a Elite Home Health and Hospice | IHS.FS.60384078 | Garfield | 2019 | 1 | 4 |
| Central Washington Homecare Services | IHS.FS.00000250 | Chelan | 2019 | 28 | 385 |
| Central Washington Homecare Services | IHS.FS.00000250 | Douglas | 2019 | 19 | 125 |
| Chaplaincy Health Care 2018 | IHS.FS.00000456 | Benton | 2019 | 96 | 700 |
| Chaplaincy Health Care 2018 | IHS.FS.00000456 | Franklin | 2019 | 26 | 164 |
| Community Home Health/Hospice | IHS.FS.00000262 | Cowlitz | 2019 | 98 | 636 |
| Community Home Health/Hospice | IHS.FS.00000262 | Wahkiakum | 2019 | 0 | 7 |
| Community Home Health/Hospice | IHS.FS.00000262 | Clark | 2019 | 60 | 453 |
| Continuum Care of King LLC | IHS.FS.61058934 | King | 2019 | 0 | 0 |
| Continuum Care of Snohomish LLC | IHS.FS.61010090 | Snohomish | 2019 | 0 | 0 |
| Envision Hospice of Washington | IHS.FS.60952486 | Thurston | 2019 | 2 | 22 |
| EvergreenHealth | IHS.FS.00000278 | King | 2019 | 225 | 2025 |
| EvergreenHealth | IHS.FS.00000278 | Snohomish | 2019 | 53 | 471 |
| EvergreenHealth | IHS.FS.00000278 | Island | 2019 | 1 | 11 |
| Franciscan Hospice | IHS.FS.00000287 | King | 2019 | 92 | 921 |
| Franciscan Hospice | IHS.FS.00000287 | Kitsap | 2019 | 118 | 757 |
| Franciscan Hospice | IHS.FS.00000287 | Pierce | 2019 | 364 | 2236 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Okanogan | 2019 | 27 | 171 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Douglas | 2019 | 0 | 5 |
| Frontier Home Health & Hospice | IHS.FS.60379608 | Grant | 2019 | 4 | 8 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Grays Harbor | 2019 | 41 | 212 |
| Harbors Home Health and Hospice | IHS.FS.00000306 | Pacific | 2019 | 15 | 98 |
| Heartlinks | IHS.FS.00000369 | Benton | 2019 | 7 | 137 |
| Heartlinks | IHS.FS.00000369 | Yakima | 2019 | 21 | 180 |
| Heartlinks | IHS.FS.00000369 | Franklin | 2019 | 0 | 2 |
| Horizon Hospice | IHS.FS.00000332 | Spokane | 2019 | 30 | 393 |
| Hospice of Jefferson County, Jefferson Healthcare | IHI.FS.00000349 | Jefferson | 2019 | 26 | 172 |
| Hospice of Spokane | IHS.FS.00000337 | Spokane | 2019 | 289 | 1692 |
| Hospice of Spokane | IHS.FS.00000337 | Stevens | 2019 | 20 | 126 |
| Hospice of Spokane | IHS.FS.00000337 | Ferry | 2019 | 5 | 25 |
| Hospice of Spokane | IHS.FS.00000337 | Pend Oreille | 2019 | 4 | 65 |
| Hospice of the Northwest | IHS.FS.00000437 | Island | 2019 | 14 | 56 |
| Hospice of the Northwest | IHS.FS.00000437 | San Juan | 2019 | 6 | 73 |
| Hospice of the Northwest | IHS.FS.00000437 | Skagit | 2019 | 77 | 705 |
| Hospice of the Northwest | IHS.FS.00000437 | Snohomish | 2019 | 5 | 58 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Skamania | 2019 | 0 | 17 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Klickitat | 2019 | 2 | 24 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Clark | 2019 | 0 | 3 |
| Inspiring Hospice Partners of Oregon dba Heart of Hospice | IHS.FS.60741443 | Snohomish | 2019 | 0 | 0 |
| Kaiser Continuing Care Services Hospice | IHS.FS.00000353 | Clark | 2019 | 43 | 387 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | King | 2019 | 37 | 489 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Kitsap | 2019 | 18 | 123 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Pierce | 2019 | 25 | 176 |
| Kaiser Permanente Home Health and Hospice | IHS.FS.00000305 | Snohomish | 2019 | 7 | 62 |
| Kindred Hospice | IHS.FS.60330209 | King | 2019 | 6 | 217 |
| Kittitas Valley Healthcare Home Health and Hospice | IHS.FS.00000320 | Kittitas | 2019 | 16 | 169 |
| Klickitat Valley Hospice | IHS.FS.00000361 | Klickitat | 2019 | 1 | 44 |
| Kline Galland Community Based Services | IHS.FS.60103742 | King | 2019 | 35 | 345 |
| Memorial Home Care Services | IHS.FS.00000376 | Yakima | 2019 | 148 | 730 |
| MultiCare Hospice | IHS.FS.60639376 | King | 2019 | 27 | 149 |
| MultiCare Hospice | IHS.FS.60639376 | Pierce | 2019 | 167 | 758 |
| MultiCare Hospice | IHS.FS.60639376 | Kitsap | 2019 | 37 | 194 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Clallam | 2019 | 23 | 234 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Jefferson | 2019 | 0 | 9 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Lewis | 2019 | 17 | 244 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Mason | 2019 | 6 | 45 |
| Northwest Healthcare Alliance, Inc. d/b/a Assured Home Health & Hospice | IHS.FS.00000229 | Thurston | 2019 | 22 | 240 |
| Olympic Medical Hospice | IHS.FS.00000393 | Clallam | 2019 | 0 | 0 |
| PeaceHealth Hospice | IHS.FS.60331226 | Clark | 2019 | 184 | 1217 |
| PeaceHealth Hospice | IHS.FS.60331226 | Cowlitz | 2019 | 23 | 99 |
| PeaceHealth Hospice | IHS.FS.60331226 | Skamania | 2019 | 0 | 1 |
| Providence Hospice | IHS.FS.60201476 | Klickitat | 2019 | 9 | 22 |
| Providence Hospice | IHS.FS.60201476 | Skamania | 2019 | 1 | 15 |
| Providence Hospice | IHS.FS.60201476 | Clark | 2019 | 0 | 0 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Snohomish | 2019 | 272 | 1613 |
| Providence Hospice and Home Care of Snohomish County | IHS.FS.00000418 | Island | 2019 | 1 | 29 |
| Providence Hospice of Seattle | IHS.FS.00000336 | King | 2019 | 338 | 2083 |
| Providence Hospice of Seattle | IHS.FS.00000336 | Snohomish | 2019 | 5 | 10 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Thurston | 2019 | 91 | 685 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Mason | 2019 | 28 | 148 |
| Providence Sound HomeCare and Hospice | IHS.FS.00000420 | Lewis | 2019 | 33 | 118 |
| Puget Sound Hopsice | IHS.FS.61032138 | Thurston | 2019 | 0 | 0 |
| Walla Walla Community Hospice | IHS.FS.60480441 | Walla Walla | 2019 | 41 | 242 |



**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Prepared by DOH Program Staff

| | | | | | |
|---|---|---|---|---|---|
| Walla Walla Community Hospice | IHS.FS.60480441 | Columbia | 2019 | 3 | 25 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Adams | 2019 | 8 | 54 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Grant | 2019 | 41 | 228 |
| Washington HomeCare and Hospice of Central Basin, LLC d/b/a Assured Hospice | IHS.FS.60092413 | Lincoln | 2019 | 3 | 22 |
| WhidbeyHealth Home Health, Hospice | IHS.FS.00000323 | Island | 2019 | 27 | 245 |
| Yakima HMA Home Health, LLC | IHS.FS.60097245 | Yakima | 2019 | 6 | 88 |
| PeaceHealth Whatcom | 0 | Whatcom | 2019 | 138 | 995 |
| Wesley Homes | IHS.FS.60276500 | King | 2019 | 5 | 86 |
| Kindred Hospice | IHS.FS.60308060 | Spokane | 2019 | 10 | 90 |
| Kindred Hospice | IHS.FS.60308060 | Whitman | 2019 | 12 | 77 |



**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Prepared by DOH Program Staff

# Department of Health
# 2020-2021 Hospice Numeric Need Methodology
*Admissions - Summarized*

**0-64 Total Admissions by County**

| Sum of 0-64 | Column Labels | | |
|---|---|---|---|
| **Row Labels** | **2017** | **2018** | **2019** |
| Adams | 4 | 6 | 8 |
| Asotin | 7 | 6 | 9 |
| Benton | 110 | 118 | 103 |
| Chelan | 44 | 34 | 28 |
| Clallam | 14 | 16 | 23 |
| Clark | 282 | 336 | 287 |
| Columbia | 1 | 1 | 3 |
| Cowlitz | 124 | 107 | 121 |
| Douglas | 19 | 10 | 19 |
| Ferry | 7 | 6 | 5 |
| Franklin | 15 | 30 | 26 |
| Garfield | 1 | 1 | 1 |
| Grant | 44 | 41 | 45 |
| Grays Harbor | 72 | 35 | 41 |
| Island | 35 | 38 | 43 |
| Jefferson | 14 | 21 | 26 |
| King | 862 | 1,009 | 765 |
| Kitsap | 104 | 180 | 173 |
| Kittitas | 46 | 15 | 16 |
| Klickitat | 17 | 10 | 12 |
| Lewis | 45 | 56 | 50 |
| Lincoln | 3 | 7 | 3 |
| Mason | 34 | 14 | 34 |
| Okanogan | 34 | 21 | 27 |
| Pacific | 17 | 13 | 15 |
| Pend Oreille | 8 | 8 | 4 |
| Pierce | 419 | 543 | 556 |
| San Juan | 3 | 6 | 6 |
| Skagit | 61 | 48 | 77 |
| Skamania | 4 | 2 | 1 |
| Snohomish | 339 | 422 | 342 |
| Spokane | 397 | 400 | 329 |
| Stevens | 25 | 30 | 20 |
| Thurston | 144 | 114 | 115 |
| Wahkiakum | 1 | 2 | 0 |
| Walla Walla | 45 | 24 | 41 |
| Whatcom | 139 | 117 | 138 |
| Whitman | 29 | 19 | 12 |
| Yakima | 188 | 248 | 175 |

**65+ Total Admissions by County**

| Sum of 65+ | Column Labels | | |
|---|---|---|---|
| **Row Labels** | **2017** | **2018** | **2019** |
| Adams | 30 | 34 | 54 |
| Asotin | 85 | 121 | 71 |
| Benton | 875 | 887 | 837 |
| Chelan | 319 | 386 | 385 |
| Clallam | 143 | 187 | 234 |
| Clark | 1,898 | 2,124 | 2,060 |
| Columbia | 17 | 23 | 25 |
| Cowlitz | 695 | 600 | 735 |
| Douglas | 129 | 136 | 130 |
| Ferry | 37 | 29 | 25 |
| Franklin | 122 | 155 | 166 |
| Garfield | 1 | 2 | 4 |
| Grant | 216 | 261 | 236 |
| Grays Harbor | 292 | 180 | 212 |
| Island | 364 | 348 | 341 |
| Jefferson | 167 | 155 | 181 |
| King | 6,739 | 6,359 | 6,315 |
| Kitsap | 1,156 | 1,021 | 1,074 |
| Kittitas | 134 | 135 | 169 |
| Klickitat | 82 | 81 | 90 |
| Lewis | 420 | 420 | 362 |
| Lincoln | 22 | 29 | 22 |
| Mason | 232 | 161 | 193 |
| Okanogan | 132 | 148 | 171 |
| Pacific | 106 | 72 | 98 |
| Pend Oreille | 55 | 53 | 65 |
| Pierce | 3,356 | 3,175 | 3,170 |
| San Juan | 70 | 79 | 73 |
| Skagit | 616 | 680 | 705 |
| Skamania | 21 | 20 | 33 |
| Snohomish | 2,084 | 2,636 | 2,214 |
| Spokane | 2,467 | 2,248 | 2,175 |
| Stevens | 128 | 121 | 126 |
| Thurston | 899 | 936 | 947 |
| Wahkiakum | 4 | 5 | 7 |
| Walla Walla | 276 | 227 | 242 |
| Whatcom | 766 | 770 | 995 |
| Whitman | 248 | 227 | 77 |
| Yakima | 962 | 977 | 998 |

**Total Admissions by County - Not Adjusted for New**

| County | 2017 | 2018 | 2019 | Average |
|---|---|---|---|---|
| Adams | 34 | 40 | 62 | **45.33** |
| Asotin | 92 | 127 | 80 | **99.67** |
| Benton | 985 | 1,005 | 940 | **976.67** |
| Chelan | 363 | 420 | 413 | **398.67** |
| Clallam | 157 | 203 | 257 | **205.67** |
| Clark | 2,180 | 2,460 | 2,347 | **2329.00** |
| Columbia | 18 | 24 | 28 | **23.33** |
| Cowlitz | 819 | 707 | 856 | **794.00** |
| Douglas | 148 | 146 | 149 | **147.67** |
| Ferry | 44 | 35 | 30 | **36.33** |
| Franklin | 137 | 185 | 192 | **171.33** |
| Garfield | 2 | 3 | 5 | **3.33** |
| Grant | 260 | 302 | 281 | **281.00** |
| Grays Harb | 364 | 215 | 253 | **277.33** |
| Island | 399 | 386 | 384 | **389.67** |
| Jefferson | 181 | 176 | 207 | **188.00** |
| King | 7,601 | 7,368 | 7,080 | **7349.67** |
| Kitsap | 1,260 | 1,201 | 1,247 | **1236.00** |
| Kittitas | 180 | 150 | 185 | **171.67** |
| Klickitat | 99 | 91 | 102 | **97.33** |
| Lewis | 465 | 476 | 412 | **451.00** |
| Lincoln | 25 | 36 | 25 | **28.67** |
| Mason | 266 | 175 | 227 | **222.67** |
| Okanogan | 166 | 169 | 198 | **177.67** |
| Pacific | 123 | 85 | 113 | **107.00** |
| Pend Oreill | 63 | 61 | 69 | **64.33** |
| Pierce | 3,775 | 3,718 | 3,726 | **3739.67** |
| San Juan | 73 | 85 | 79 | **79.00** |
| Skagit | 677 | 728 | 782 | **729.00** |
| Skamania | 25 | 22 | 34 | **27.00** |
| Snohomish | 2,423 | 3,058 | 2,556 | **2679.00** |
| Spokane | 2,864 | 2,648 | 2,504 | **2671.83** |
| Stevens | 153 | 151 | 146 | **150.00** |
| Thurston | 1,043 | 1,050 | 1,062 | **1051.67** |
| Wahkiakun | 5 | 7 | 7 | **6.33** |
| Walla Wall | 321 | 251 | 283 | **285.00** |
| Whatcom | 905 | 887 | 1,133 | **975.00** |
| Whitman | 277 | 246 | 89 | **203.83** |
| Yakima | 1,150 | 1,225 | 1,173 | **1182.67** |

**Total Admissions by County - Adjusted for New**

Adjusted Cells Highlighted in YELLOW

| County | 2017 | 2018 | 2019 | Average |
|---|---|---|---|---|
| Adams | 34 | 40 | 62 | **45.33** |
| Asotin | 92 | 127 | 80 | **99.67** |
| Benton | 985 | 1,005 | 940 | **976.67** |
| Chelan | 363 | 420 | 413 | **398.67** |
| Clallam | 157 | 203 | 461 | **273.63** |
| Clark | 2,180 | 2,460 | 2,551 | **2,396.97** |
| Columbia | 18 | 24 | 28 | **23.33** |
| Cowlitz | 819 | 707 | 856 | **794.00** |
| Douglas | 148 | 146 | 149 | **147.67** |
| Ferry | 44 | 35 | 30 | **36.33** |
| Franklin | 137 | 185 | 192 | **171.33** |
| Garfield | 2 | 3 | 5 | **3.33** |
| Grant | 260 | 302 | 281 | **281.00** |
| Grays Harb | 364 | 215 | 253 | **277.33** |
| Island | 399 | 386 | 384 | **389.67** |
| Jefferson | 181 | 176 | 207 | **188.00** |
| King | 7,787 | 7,368 | 7,397 | **7,517.23** |
| Kitsap | 1,260 | 1,201 | 1,451 | **1,303.97** |
| Kittitas | 180 | 150 | 185 | **171.67** |
| Klickitat | 282 | 271 | 280 | **277.57** |
| Lewis | 465 | 476 | 412 | **451.00** |
| Lincoln | 25 | 36 | 25 | **28.67** |
| Mason | 266 | 175 | 227 | **222.67** |
| Okanogan | 166 | 169 | 198 | **177.67** |
| Pacific | 123 | 85 | 113 | **107.00** |
| Pend Oreill | 63 | 61 | 69 | **64.33** |
| Pierce | 3,775 | 3,718 | 3,726 | **3,739.67** |
| San Juan | 73 | 85 | 79 | **79.00** |
| Skagit | 677 | 728 | 782 | **729.00** |
| Skamania | 25 | 22 | 34 | **27.00** |
| Snohomish | 2,423 | 3,058 | 3,372 | **2,950.87** |
| Spokane | 2,864 | 2,648 | 2,504 | **2,671.83** |
| Stevens | 153 | 151 | 146 | **150.00** |
| Thurston | 1,043 | 1,254 | 1,446 | **1,247.57** |
| Wahkiakun | 5 | 7 | 7 | **6.33** |
| Walla Wall | 321 | 251 | 283 | **285.00** |
| Whatcom | 905 | 887 | 1,337 | **1,042.97** |
| Whitman | 277 | 246 | 89 | **203.83** |
| Yakima | 1,150 | 1,225 | 1,173 | **1,182.67** |

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Prepared by DOH Program Staff

# Department of Health
# 2020-2021 Hospice Numeric Need Methodology
*Admissions - Summarized*

35 ADC * 365 days per year = 12,775 default patient days
12,775 patient days/62.66 ALOS = 203.9 default admissions
203.9 Default
For affected counties, the actual volumes from these recently approved agnecies will be subtracted, and default values will be added.

**Recent approvals showing default volumes:**
Wesley Homes Hospice - King County. Approved in 2015, operational since 2017. 2018 volumes exceed "default" - no adjustment for 2018. Adjustments in 2017 and 2019.
Heart of Hospice - Klickitat County. Approved in August 2017. Operational since August 2017. Default volumes in 2017-2019.
Envision Hospice - Thurston County. Approved in September 2018. Default volumes in 2018-2019.
Continuum Care of Snohomish - Snohomish County. Approved in July 2019. Default volumes in 2019.
Olympic Medical Center - Clallam County. Approved in September 2019. Default volumes for 2019.
Symbol Healthcare - Thurston County. Approved in November 2019. Default volumes for 2019.
Heart of Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019.
Envision Hospice - Snohomish County. Approved in November 2019. Default volumes for 2019.
Glacier Peak Healthcare - Snohomish County. Approved in November 2019. Default volumes for 2019.
Providence Hospice - Clark County. Approved in 2019. Default volumes in 2019.
Envision Hospice - King County. Approved in 2019. Default volumes for 2019.
EmpRes Healthcare Group - Whatcom County. Approved in 2019 review cycle. No adjustment possible for 2020, adjustment in 2019 as proxy.
Envision Hospice - Kitsap County. Approved in 2019 review cycle. No adjustment possible for 2020, adjustment in 2019 as proxy.

**Source:**
Self-Report Provider Utilization Surveys for Years 2017-2019
Prepared by DOH Program Staff

**EXHIBIT 7: Hospice 4-021 Admission Criteria and Process and the Hospice 4-096 Intake Process Policy**

# ADMISSION CRITERIA AND PROCESS
**Policy No. 4-021.1**

## PURPOSE

To establish standards and a process by which a patient can be evaluated and accepted for admission.

## POLICY

Signature Healthcare at Home will admit any patient with a life-limiting illness that meets the admission criteria.

Patients will be accepted for care without discrimination on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, place of national origin, income level, or other underserved groups.

Patients will be accepted for care based on need for hospice services. Consideration will be given to the adequacy and suitability of hospice personnel, resources to provide the required services, and a reasonable expectation that the patient's hospice care needs can be adequately met in the patient's place of residence. (See "Scope of Services" Policy No. 1-024.)

While patients are accepted for services based on their hospice care needs, the patient's ability to pay for such services, whether through state or federal assistance programs, private insurance, or personal assets is a factor that will be considered.

The patient's life-limiting illness and prognosis of six (6) months or less will be determined by utilizing standard clinical prognosis criteria developed by the fiscal intermediary's Local Coverage Determinations (LCDs).

Signature Healthcare at Home reserves the right not to accept any patient who does not meet the admission criteria.

A patient will be referred to other resources if Signature Healthcare at Home cannot meet his/her needs.

Once a patient is admitted to service, the organization will be responsible for providing care and services within its financial and service capabilities, mission, and applicable law and regulations.

### *Admission Criteria*

1. Signature Healthcare at Home will admit a patient only on recommendation of the Medical Director or Hospice Physician in consultation with, or input from, the patient's attending physician, if any.

2. The patient must be under the care of a physician. The patient's physician (or other authorized independent practitioner) must order and approve the provision of hospice care, be willing to sign or have a representative who is willing to sign the death certificate, and be willing to discuss the patient's resuscitation status with the patient and family/caregiver.

3. The patient must identify a family member/caregiver or legal representative who agrees to be a primary support care person if and when needed. Persons without such an identified individual and who are independent in their activities of daily living (ADLs) will require a specific plan to be developed at time of admission with the social worker.

4. The patient must have a life-limiting illness with a life expectancy of six (6) months or less, as determined by the attending physician and hospice Medical Director, utilizing standard clinical prognosis criteria developed by LCD.

5. The patient must desire hospice services, and be aware of the diagnosis and prognosis.

6. The focus of care desired must be palliative versus curative.

7. The patient and family/caregiver desire hospice care, agree to participate in the plan of care, and sign the consent form for hospice care.

8. The patient and family/caregiver agree that patient care will be provided primarily in the patient's residence, which could be his/her private home, a family member's home, a skilled nursing facility, or other living arrangements.

9. The physical facilities and equipment in the patient's home must be adequate for safe and effective care.

10. The patient must reside within the geographical area that the Signature Healthcare at Home services.

11. Eligibility for participation will not be based on the patient's race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, or place of national origin.

12. If applicable, the patient must meet the eligibility criteria for Medicare, Medicaid, or private insurance hospice benefit reimbursement.

13. Eligibility criteria will be continually reviewed on an ongoing basis by the interdisciplinary team to assure appropriateness of hospice care.

## PROCEDURE

1. The organization will utilize referral information provided by family/caregiver, health care clinicians from acute care facilities, skilled or intermediate nursing facilities, other agencies, and physician offices in the determination of eligibility for admission to the program. If the request for service is not made by the patient's physician, he/she will be consulted prior to the initiation of services.

2. The Clinical Supervisor will assign hospice personnel to conduct initial assessments of eligibility for services within the time frame requested by the referral source, or based on the information regarding the patient's condition or as ordered by the physician (or other authorized independent practitioner).

3. Assignment of appropriate hospice personnel to conduct the initial assessments of patient's eligibility for admission will be based on:

   A. Patient's geographical location

   B. Complexity of patient's hospice care needs/level of care required

   C. Hospice personnel's education and experience

   D. Hospice personnel's special training and/or competence to meet patient's needs

   E. Urgency of identified need for assessment

4. In the event that the time frame for assessment cannot be met, the patient's physician and the referral source, as well as the patient, will be notified for approval of the delay.

   A. Such notification and approval will be documented.

   B. If approval is not obtained for the delay, the patient will be referred to another hospice for services.

5. The initial home visit will be made within the time frame requested by the referral source and according to organization policy, or as ordered by the physician (or other authorized independent practitioner). The initial assessment may be completed during this visit. The purpose of the initial visit will be to:

   A. Explain the hospice philosophy of palliative care with the patient and family/caregiver as unit of care.

   B. Provide a written copy and explain (verbally) the patient's rights and responsibilities and grievance procedure. (See "Patient Bill of Rights" Policy No. 2-002.)

   C. Provide the patient with a copy of Signature Healthcare at Home notice of privacy practices.

   D. Assess the family/caregiver's ability to provide care.

   E. Evaluate physical facilities and equipment in the patient's home to determine if they are safe and effective for care in the home.

   F. Allow the patient and family/caregiver to ask questions and facilitate a decision for hospice services especially provided under the Medicare/Medicaid hospice benefit.

G. Review appropriate forms and subsequently sign forms by patient and family/caregiver once agreement for the hospice program has been decided.

H. Provide services as needed and ordered by physician (or other authorized independent practitioner), and incorporate additional needs into the hospice plan of care.

I. Give patient information about durable power of attorney for health care, if the patient has not already done so.

6. During the initial assessment visit, the admitting clinician will assess the patient's eligibility for hospice services according to the admission criteria and standard prognosis criteria to determine/confirm further:

   A. Level of services required and frequency criteria

   B. Eligibility (according to organization admission criteria)

   C. Source of payment

7. If eligibility criteria is met the patient and family/caregiver will be provided with a hospice brochure and various educational materials providing sufficient information on:

   A. Nature and goals of care and/or service

   B. Hours during which care or service are available (physician, nursing, drugs and biological are available 24 hours/day. All other services are available to meet individual patient care needs)

   C. Access to care after hours

   D. Costs/charges to the patient, if any, for care, treatment or services

   E. Hospice mission, objectives, and scope of care provided directly and those provided through contractual agreement

   F. Safety information

   G. Infection control information

   H. Emergency preparedness plans

   I. Available community resources

   J. Complaint/grievance process

K. Advance Directives

L. Availability of spiritual counseling in accordance with religious preference

M. Hospice personnel to be involved in care

N. Mechanism for notifying the patient and family/caregiver of changes in care and any related liability for payment as a result of those changes

8. At the time the patient elects hospice, hospice personnel will document that the above information has been furnished to the patient and family/caregiver and any information not understood by the patient and family/caregiver.

9. The patient and family/caregiver, after review, will be given the opportunity to either accept or refuse services.

10. The patient or his/her representative will sign the required forms indicating election of hospice care and receipt of patient rights and privacy information.

11. Refusal of services will be documented in the clinical record. Notification of the Clinical Supervisor, attending physician, and referral source will be completed and documented in the clinical record.

12. The hospice registered nurse will assist the family in understanding changes in the patient's status related to the progression of an end-stage disease.

13. The hospice registered nurse will educate the family in techniques for providing care.

14. The hospice registered nurse will contact the physician for clinical information in writing to certify patient for hospice care.

15. The hospice registered nurse will complete an initial assessment visit within 48 hours after the election of the hospice care (unless the physician, patient or representative requests that the initial assessment be completed in less than 48 hours.) (See "Initial Assessment" Policy No. 4-041.)

16. The hospice registered nurse will contact at least one (1) other member of the interdisciplinary group for input into the plan of care, prior to the delivery of care. The two (2) remaining core services must be contacted and provide input into the plan of care within two (2) days of start of care; this may be in person or by phone.

17. If the patient is accepted for hospice care, a comprehensive assessment of the patient will be performed no later than 5 calendar days after the election of hospice care. A plan of care will be developed by the attending hospice physician, the Medical Director or physician designee, and the hospice team. It will then be submitted to the attending physician for signature. The patient's wishes/desires will be considered and respected in the development of the plan of care. (See "Comprehensive Assessment" Policy No. 4-042.)

18. The time frames will apply for weekends and holidays, as well as weekday admissions.

19. A clinical record will be initiated for each patient admitted for hospice services.

20. If a patient does not meet the admission criteria or cannot be cared for by Signature Healthcare at Home, the Clinical Supervisor should be notified and appropriate referrals to other sources of care made on behalf of the patient.

21. The following individuals should be notified of non-admits:

    A. Patient

    B. Physician

    C. Referral source (if not physician)

22. A record of non-admits will be kept for statistical purposes, with date of referral, date of assessment, patient name, services required, physician, reason for non-admit, referral to other hospice care facilities, etc.

23. In instances where patient does not meet the stated criteria for admission to the program, exceptions will be decided upon by the Executive Director/Administrator in consultation with the Medical Director, upon request of the referring party and/or the patient.

24. In instances where continued care to a patient contradicts the recommendations of an external or internal entity performing a utilization review, the Executive Director/Administrator will be notified. All care, service, and discharge decisions must be made in response to the care required by the patient, regardless of the external or internal organization's recommendation. The patient and family/caregiver, as appropriate, and physician will be involved in deliberations about the denial of care or conflict about care decisions.

25. A record of conflict of care issues and outcomes will be kept for statistical purposes, referencing the date of the conflict of care issue, the patient name, the external or internal organization recommendations and reasons, and complete documentation of organization decision and patient care needs.

# INTAKE PROCESS
**Policy No. 4-096.1**

## PURPOSE

To establish the process for acceptance and entry of patient into the organization.

## POLICY

Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into hospice service.

The organization accepts only those patients whose needs can be met by the services it provides.

## PROCEDURE

1. Referrals will be documented on a referral and intake form or within the electronic medical record.

2. Referrals for hospice services may be accepted by the intake coordinator, nurses, social worker or other clinicians/team members, as deemed appropriate by the Administrator.

3. Referral information may be accepted by any of the following methods:

   A. Telephone

   B. Fax

   C. Written order

   D. Secure email

4. Referrals may be accepted from any of the following:

   A. Licensed Health Care Providers

   B. Discharge planners from inpatient and outpatient services

   C. Social service agencies

   D. Individual patients or their family/caregiver(s)

   E. Case Managers and/or insurance company representative

   F. Other health care organizations

5. During scheduled business hours (office hours are from 8:00 a.m. to 5:00 p.m., Monday through Friday except for holidays or determined by the Administrator or designee), calls will be transferred to a staff member designated to accept referrals.

    A. To accept referrals, information regarding a patient's demographics, diagnosis, services needed, medications, attending physician, and hospitalization, will be taken in order to make the initial determination of whether the patient's needs can be met and if he/she meets the eligibility criteria. (See "Admission Criteria and Process" Policy No. 4-021.) The information is reviewed for completeness.

    B. When the payer source is private insurance, the insurance coverage will be verified and an insurance information form completed.

    C. Intake information is given to the Clinical Manager and discussed with the hospice Medical Director for review and to assist in determining eligibility.

    D. If the referral is not from a physician, the patient's physician (or other authorized licensed independent practitioner) will be contacted to confirm service needs, as well as the patient's medical prognosis and supporting documentation, and to obtain verbal orders.

    E. The Clinical Supervisor will assign personnel and an initial assessment visit will be scheduled. The initial assessment visit will be performed either within 48 hours of the referral, or within 48 hours of a patient's return home, or on the start of care date ordered by the physician (or other authorized licensed independent practitioner).

    F. If service cannot be provided, intake personnel will give the caller the names of other agencies that can provide the required services. A log will be maintained on all patients that cannot be serviced.

6. After scheduled business hours (weekends and evenings) the organization can be accessed through the answering service.

    A. The answering service will contact the nurse on-call.

    B. The on-call nurse will complete the initial intake information from the referral source and relay the information as follows:

        1. If the referral is received after 5pm, weekend, or a holiday, the on-call nurse will complete the intake tasks to proceed with the hospice admission process.

**EXHIBIT 8: Hospice 3-007 Charity Care, plus its two appendixes: HO 3-007A. Sliding Fee Scale and HO 3-007B. Discount Application**

# CHARITY CARE
**Policy No. 3-007.1**

## PURPOSE

To identify the criteria to be applied when accepting patients for charity care.

## POLICY

Patients without third-party payer coverage and who are unable to pay for medically necessary care will be accepted for charity care admission, per established criteria.

Signature Healthcare at Home will establish objective criteria and financial screening procedures for determining eligibility for charity care. Refer to established Sliding Fee Scale appendix 3-007.A and Discount Application appendix 3-007.B.

The organization will consistently apply the charity care policy.

## PROCEDURE

1. When it is identified that the patient has no source for payment of services and requires medically necessary care/service, the patient must provide personal financial information upon which the determination of charity care will be made.

2. A social worker, as available, will meet with the patient to determine potential eligibility for financial assistance from other community resources.

3. The Executive Director/Administrator, with the appropriate program director, will review all applicable patient information, including financial declarations, physician (or other authorized licensed independent practitioner) orders, initial assessment information, and social work notes to determine acceptance for charity care.

4. All documentation utilized in the determination for acceptance for charity care will be maintained in the patient's billing record.

5. When financial declarations reveal the patient is able to make partial payment for services, the Executive Director/Administrator, with the appropriate program director, will determine the sliding-fee schedule to be implemented.

6. The revised sliding-fee schedule will be presented to the patient for agreement and signature.

7. After acceptance for charity care, the patient's ability to pay will be reassessed every 60–90 days.

8. When the organization is unable to admit the patient or to continue charity care, every effort will be made to refer the patient for appropriate care/service with an alternate provider.

9. The referral source will be advised of acceptance, non-acceptance, continuation, or discharge from charity care.

## Appendix A: Sliding Fee Schedule

| Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty | | | | | | |
|---|---|---|---|---|---|---|
| **Poverty Level*** | **At or Below 100%** | **125%** | **150%** | **175%** | **200%** | **Above 200%** |
| **Family Size** | **Charge** | | | | | |
| | **Nominal Fee ($5)** | **20% pay** | **40% pay** | **60% pay** | **80% pay** | **100% pay** |
| **1** | 0-$12,490 | $12,491-$15,613 | $15,614-$18,735 | $18,736-$21,858 | $21,859-$24,980 | $24,981+ |
| **2** | 0-$16,910 | $16,911-$21,138 | $21,139-$25,365 | $25,366-$29,593 | $29,594-$33,820 | $33,821+ |
| **3** | 0-$21,330 | $21,331-$26,663 | $26,664-$31,995 | $31,996-$37,328 | $37,329-$42,660 | $42,661+ |
| **4** | 0-$25,750 | $25,751-$32,188 | $32,189-$38,625 | $38,626-$45,063 | $45,064-$51,500 | $51,501+ |
| **5** | 0-$30,170 | $30,171-$37,713 | $37,714-$45,255 | $45,256-$52,798 | $52,799-$60,340 | $60,341+ |
| **6** | 0-$34,590 | $34,591-$43,238 | $43,239-$51,885 | $51,886-$60,533 | $60,534-$69,180 | $69,181+ |
| **7** | 0-$39,010 | $39,011-$48,763 | $48,764-$58,515 | $58,516-$68,268 | $68,269-$78,020 | $78,021+ |
| **8** | 0-$43,430 | $43,431-$54,288 | $54,289-$65,145 | $65,146-$76,003 | $76,004-$86,860 | $86,861+ |
| **For each additional person, add** | $4,420 | $5,525 | $6,630 | $7,735 | $8,840 | $8,840 |

*Based on 2019 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. Please note that there are separate guidelines for Alaska and Hawaii, and that the thresholds would differ for sites in those two states. Sites in Puerto Rico and other outlying jurisdictions would use the above guidelines

## Appendix B: Sliding Fee Discount Application

**Signature Healthcare at Home**

**Sliding Fee Discount Information**
It is the policy of Signature Hospice to provide hospice per diem services for hospice eligible patients regardless of the patient's ability to pay. Signature Hospice offers discounts based on family size and annual income.

Please complete the following information to determine if you are eligible for a discount.

The discount will apply to hospice services received at Signature Hospice, but not those services or equipment purchased from outside, including physician visits, laboratory testing, x-ray or other diagnostic tests, drugs unrelated to terminal prognosis, unapproved hospital visits or ambulance charges, and other such services. You must complete this form every 12 months or if your financial situation changes.

| NAME OF HEAD OF HOUSEHOLD | | | PLACE OF EMPLOYMENT | |
|---|---|---|---|---|
| STREET | CITY | STATE | ZIP | PHONE |
| | | | | |

**Please list spouse and dependents under age 18.**

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| SELF | | DEPENDENT | |
| SPOUSE | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |

| Source | Self | Spouse | Other | Total |
|---|---|---|---|---|
| Gross wages, salaries, tips, etc. | | | | |
| Income from business, self-employment, and dependents | | | | |
| Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement | | | | |
| Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources | | | | |
| **Total Income** | | | | |

**NOTE:** Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

**I certify that the family size and income information shown above is correct.**

| | | | |
|---|---|---|---|
| Name (Print) | | | |
| Signature | | Date | |

**Office Use Only**

**Patient Name:** _____
**Approved Discount:** _____
**Approved by:** _____
**Date Approved:** _____

| Verification Checklist | Yes | No |
|---|---|---|
| Identification/Address: Driver’s license, utility bill, employment ID, or | | |
| Income: Prior year tax return, three most recent pay stubs, or other | | |
| Insurance: Insurance Cards | | |

**EXHIBIT 9: Hospice 2-002 Patient Bill of Rights.**

# PATIENT BILL OF RIGHTS
**Policy No. 2-002.1**

## PURPOSE

To encourage awareness of patient rights, to provide guidelines to assist patients making decisions regarding care, and to support active participation in care planning.

## POLICY

Each patient will be an active, informed participant in his/her plan of care. To ensure this process, the patient will be empowered with certain rights as described. The rights contained within this policy include the basic rights of the patient. Additional rights may be required by program specific standards and will be found in program specific policy.

A patient may designate someone to act as his/her representative. This representative, on behalf of the patient, may exercise any of the rights provided by the policies and procedures established by the organization.

To assist with fully understanding patient rights, all policies will be available to organization personnel, the patient, and his/her representatives as well as other organizations and the interested public.

## PROCEDURE

1. The Patient Bill of Rights statement defines the right of the patient to:

    A. Exercise and understand his or her rights and responsibilities as a patient of Signature Healthcare at Home and not to be subject to discrimination or reprisal for exercising these rights.

    B. Receive effective pain and symptom management for conditions related to the terminal illness(es) and choose a health care provider (including an attending physician).

    C. Have his or her property and person treated with respect, consideration and recognition of patient dignity and individuality.

    D. Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the organization and must not be subjected to discrimination or reprisal for doing so.

    E. Receive an investigation by the organization of complaints made by the patient or the patient's family or guardian regarding treatment or care that is (or fails to be) furnished, or regarding lack of respect for the patient's property by anyone furnishing services on behalf of the organization; the existence of the complaint and the resolution of the complaint must be documented.

F. Be informed in advance of service about the care to be furnished, the organization's scope of services and services under the Medicare Hospice Benefit and any limitations on these services.

G. Be advised in advance of the right to participate in planning the care or service and in planning changes in the care and service.

H. Confidentiality of the patient and clinical records maintained by the organization and the policies and procedures regarding disclosure.

I. Be free from mistreatment, neglect or verbal, mental, sexual and physical abuse, including injuries of an unknown source, and misappropriation of patient property.

J. Refuse care or treatment after the consequences of refusing care or treatment are fully presented.

K. Receive care/service without discrimination in accordance with physician orders.

L. Be informed, verbally and in writing, of billing and reimbursement methodologies prior to the start of care/service and as changes occur, including fees for services/products provided, direct pay responsibilities, and notification of insurance coverage.

M. Receive in writing, prior to the start of care, the telephone numbers for the ACHC Hotline, including hours of operation, and the purpose of the hotlines to receive complaints or questions about the organization *(if the agency is ACHC accredited).*

N. Be informed of patient rights under state law to formulate Advance Directives.

O. Use the hotlines to lodge complaints concerning the implementation of Advance Directive requirements.

P. Be able to identify visiting personnel through proper identification.

Q. Be informed of disciplines furnishing care and the frequency of visits.

R. Recommend changes in policies and procedures, personnel or care/service.

S. Be informed of any financial benefits when referred to a hospice.

T. Be informed of anticipated outcomes of care and any barriers in outcome achievement.

U. Be informed of the patient's responsibilities.

2. Upon admission, the admitting clinician/technician will provide each patient or his/her representative with a written copy of the Patient Bill of Rights.

3. The Patient Bill of Rights will be explained (verbally/orally) and distributed to the patient prior to the initiation of organization services. This explanation will be in a language and manner he/she can reasonably be expected to understand.

4. The patient's/representative's signature on the Informed Consent acknowledges that the patient received a copy of the Patient Bill of Rights. The patient's refusal to agree to the Bill of Rights will be documented in the clinical record, including the reason for refusal.

5. The admitting clinician will document that the patient has received a copy of the Patient Bill of Rights.

   A. If the patient is unable to understand his/her rights and responsibilities, documentation in the clinical note will be made.

   B. In the event a communication barrier exists, if possible, special devices or interpreters will be made available.

   C. Written information will be provided to patients in the predominant languages of the population served.

6. The family or guardian may exercise the patient's rights when a patient is incompetent or a minor.

7. All organization personnel, both clinical and non-clinical, will be oriented to the patient's rights and responsibilities prior to the end of their orientation program, as well as annually. (See "Patient Privacy Rights" Policy No. 2-012.)

**EXHIBIT 10: Hospice 2-037 Non-Discrimination Policy and Grievance Process**

# NONDISCRIMINATION POLICY AND GRIEVANCE PROCESS
**Policy No. 2-037.1**

## PURPOSE

To prevent organization personnel from discriminating against other personnel, patients, or other organizations on the basis of race, color, religion, age, gender, sexual orientation, disability (mental or physical), communicable disease, place of national origin, income level, or other underserved groups.

## POLICY

In accordance with Title VI of the Civil Rights Act of 1964, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Signature Healthcare at Home will, directly or through contractual or other arrangement, admit and treat all persons without regard to race, color, or place of national origin in its provision of services and benefits, including assignments or transfers within facilities.

In accordance with Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulations, Signature Healthcare at Home will not, directly or through contractual or other arrangements, discriminate on the basis of disability (mental or physical) in admissions, access, treatment or employment.

In accordance with the Age Discrimination Act of 1975, Section 1557 of the Affordable Care Act (ACA) of 2010 and its implementing regulation, Signature Healthcare at Home will not, directly or through contractual or other arrangements, discriminate on the basis of age in the provision of services unless age is a factor necessary to the normal operation or the achievement of any statutory objective.

In accordance with Title II of the Americans with Disabilities Act of 1990, Signature Healthcare at Home will not, on the basis of disability, exclude or deny a qualified individual with a disability from participation in, or benefits of, the services, programs or activities of the organization.
In accordance with other regulations the organization will not discriminate in admissions, access, treatment, or employment on the basis of gender, sexual orientation, religion, or communicable disease.

## PROCEDURE

1. The Section 504/ADA Compliance Coordinator and Section 1557 Civil Rights Coordinator (can be same person) designated to coordinate the efforts of Signature Healthcare at Home to comply with the regulations will be the Executive Director/Administrator.

2. Signature Healthcare at Home will identify an organization or person in their service area who can interpret or translate for persons with limited English proficiency and who can disseminate information to and communicate with sensory impaired persons. These contacts will be listed and kept in the policy manual. (See “Facilitating Communication” Policy No. 2-038.)

3. A copy of this policy will be posted in the reception area of Signature Healthcare at Home, given to each organization staff member, and sent to each referral source.

4. A nondiscrimination statement (See #5) will be posted in a conspicuous place, such as the reception area of the organization and will be printed on brochures, other printed public materials and in a conspicuous location on the organization's web site accessible from the home page, in English and at least the top 15 non-English languages spoken in the state.

5. The nondiscrimination statement will read: *"Signature Healthcare at Home complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Signature Healthcare at Home does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Signature Healthcare at Home provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written materials in other formats (e.g. large print, audio, accessible electronic formats). Signature Healthcare at Home provides free language services to people whose primary language is not English such as qualified interpreters and information written in other languages. If you need these services, contact the Section 504/ADA Coordinator/Section 1557 Civil Rights Coordinator at 901-224-2066. If you believe that Signature Healthcare at Home has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex you can file a grievance with Tim Esau, Chief Compliance and Privacy Officer, 25115 SW Parkway Ave, Suite C, Wilsonville, OR 97070, phone 901-224-2066, fax 866-751-4130, email tesau@avamere.com.*
*You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tim Esau is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Compliant Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 2020; 1-800-368-1019, 800-537- 7697(TDD)"*

6. Any person who believes she or he has been subjected to discrimination or who believes he or she has witnessed discrimination, in contradiction of the policy stated above, may file a grievance under this procedure. It is against the law for Signature Healthcare at Home to retaliate against anyone who files a grievance or cooperates in the investigation of a grievance.

7. Grievances must be submitted to the Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator within 60 days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

8. A complaint may be filed in writing, or verbally, containing the name and address of the person filing it ("the grievant"). The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought by the grievant.

9. The Section 504 Coordinator/Section 1557 Civil Rights Coordinator (or her/his representative) will conduct an investigation of the complaint to determine its validity. This

investigation may be informal, but it must be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint.

10. The Section 504/ADA Compliance Coordinator/ Section 1557 Civil Rights Coordinator will issue a written decision on the grievance no later than 30 days after its filing.

11. The grievant may appeal the decision of the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator by filing an appeal in writing to Signature Healthcare at Home within 15 days of receiving the Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator's decision.

12. Signature Healthcare at Home will issue a written decision in response to the appeal no later than 30 days after its filing.

13. The Section 504/ADA Compliance Coordinator/Section 1557 Civil Rights Coordinator will maintain the files and records of Signature Healthcare at Home relating to such grievances.

14. The availability and use of this grievance procedure does not preclude a person from filing a complaint of discrimination on the basis of handicap with the regional office for Civil Rights of the U.S. Department of Health and Human Services.

15. All organization personnel will be informed of this process during their orientation process.

16. Signature Healthcare at Home will make appropriate arrangements to assure that persons with disabilities can participate in or make use of this grievance process on the same basis as the nondisabled. Such arrangements may include, but will not be limited to, the providing interpreters for the deaf, providing taped cassettes of material for the blind, or assuring a barrier-free location for the proceedings. The Section 504 Coordinator will be responsible for providing such arrangements.

**EXHIBIT 11: Hospice 4-075 Discharge from Hospice Program policy and Hospice 2-001 Availability of Services policy.**

# AVAILABILITY OF SERVICES
**Policy No. 2-001.1**

## PURPOSE

To define the availability of services to the community.

## POLICY

Care and services will be available to the Signature Healthcare at Home patients 24 hours per day, seven (7) days per week.

Personnel will be available to accept referrals to hospice services 24 hours a day, seven (7) days per week.

The initial assessment visit must be performed within 48 hours after election of hospice care.

The comprehensive assessment will be completed no later than 5 calendar days after the election of hospice care.

Routine visits will be performed on weekends or after regular business hours when dictated by the type of care required (e.g., daily wound care, every 12 hour medication administration), when specifically ordered by the physician (or other authorized licensed independent practitioner), or upon the patient's preference.

# DISCHARGE FROM HOSPICE PROGRAM
**Policy No. 4-075.1**

## PURPOSE

To establish standards and a process by which patients are discharged from the hospice program.

## POLICY

Signature Healthcare at Home will provide service to a patient and family/caregiver as long as the patient remains terminally ill and lives in the designated service area.

***Discharge Criteria***

1. The Medical Director and/or attending physician will determine the patient is not hospice-appropriate according to standard clinical criteria for determining disease prognosis of six (6) months or less.

2. Patient leaves service area of Signature Healthcare at Home or transfers to another hospice.

3. Environment is determined to be unsafe for the patient and/or staff.

4. The patient and family/caregiver request discharge.

5. The patient revokes hospice election.

6. The patient or family/caregiver refuses to allow the hospice physician or nurse practitioner to have the required face-to-face encounter (prior to 3rd and subsequent benefit periods).

## PROCEDURE

1. The hospice interdisciplinary group will develop a discharge plan.

2. The Case Manager will ensure that necessary paperwork is completed at the time of discharge. This will include a signed revocation form, if necessary, and a written physician order to discharge.

3. Part of the discharge process includes assisting the patient/family/caregiver to ensure the following:

    A. PCP is in place
    B. DME and medication needs are met
    C. Spiritual and/or psychosocial needs are met
    D. Personal care needs are met

4. When a patient is discharged, transferred, or referred to another organization, relevant information will include:

   A. Reason for transfer or discharge

   B. Physical and psychosocial status at time of transfer or discharge, including specific medical, psychosocial, or other problems requiring interventions or follow-up

   C. Summary of the care provided and progress toward achieving goals, including both positive and adverse patient responses to treatment or services

   D. A copy of the current plan of care

   E. A copy of the medication profile, including discontinued medications

   F. The latest physician orders

   G. Continuing symptom management needs, e.g., pain, nausea, dyspnea

   H. Follow-up to be provided by an interdisciplinary team member from the service transferring the patient

   I. All pertinent laboratory data

   J. Summary of patient education provided to the patient and his/her comprehension of that information.

   K. Instruction and referrals provided to the patient

   L. Existence of any Advance Directives, if applicable

   M. The date of discharge

5. Documentation will be filed in the clinical record. Information will be documented on a discharge/transfer form, which is to be completed within 72 hours.

6. If the environment is determined unsafe for the patient and/or staff, the following steps will be taken:

   A. Provide written recommendations to patient and family/caregiver and physician to resolve unsafe situation.

   B. Refer to social worker for assistance with placement planning.

   C. Consult with adult/child protective services and document.

   D. Consider referrals to other agencies.

E. A formal letter will be provided to the patient and/or his/her representative that includes the organization's concern, recommendations, consequences if concerns are not resolved, and potential discharge date unless there are immediate safety concerns. A copy will be provided to the attending physician.

7. If the hospice determines the patient should be discharged for the cause of disruptive, abusive or uncooperative behavior, the following steps will be taken:

   A. Advise the patient and/or caregiver that a discharge for cause is being considered.

   B. Make a serious effort to resolve the problem(s) caused by the behavior or situation of a patient or other persons in the patient's home and document problems and efforts made to resolve it in the clinical record.

   C. Determine that the patient's proposed discharge is not due to the patient's use of necessary hospice services.

   D. Prior to discharging a patient for cause, the hospice IDG must obtain a written discharge order from the hospice medical director. If the patient has an attending physician involved in the care, this physician should be consulted before discharge and his/her review and decision should be included in the discharge note.

   E. The hospice should also consider referrals to other appropriate and/or relevant state/community agencies (e.g. Adult Protective Services) or health care facilities prior to discharge.

   F. The hospice notifies its Medicare Administrative Contractor (MAC) and the state licensure agency of the circumstances surrounding the impending discharge for cause.

8. A copy of the discharge summary will be sent to the attending physician. If requested, the patient's clinical record will be provided.

**EXHIBIT 12: Signature Hospice Pierce, LLC Projections: P&L, Balance Sheet, Cash Flow, Staffing, & Assumptions**

| Pierce Hospice P&L | | Year 1 (2022) | Year 2 (2023) | Year 3 (2024) |
|---|---|---|---|---|
| Admissions | | 99 | 153 | 215 |
| Visits per patient | | 16 | 16 | 16 |
| Average Length of Stay | | 62.66 | 62.66 | 62.66 |
| Rate per Day | | 191.37 | 191.36 | 191.35 |
| Patient Days | | 6203.34 | 9586.98 | 13471.90 |
| Average Daily Census | | 17.00 | 26.27 | 36.91 |
| | | | | |
| Medicare | 95% | $ 1,127,776.52 | $ 1,742,836.27 | $ 2,448,955.66 |
| Managed Medicare | 0% | $ - | $ - | $ - |
| Medicaid | 4% | $ 47,485.33 | $ 73,382.58 | $ 103,113.92 |
| Commercial | 1% | $ 11,871.33 | $ 18,345.64 | $ 25,778.48 |
| **Total Revenue** | | **$ 1,187,133.18** | **$ 1,834,564.49** | **$ 2,577,848.07** |
| **Revenue Reductions** | | | | |
| Sequestration | 2% | $ 22,555.53 | $ 34,856.73 | $ 48,979.11 |
| Bad Debt | 1% | $ 11,871.33 | $ 18,345.64 | $ 25,778.48 |
| Charity | 1% | $ 11,871.33 | $ 18,345.64 | $ 25,778.48 |
| | | | | |
| **Net Revenue** | | **$ 1,140,834.98** | **$ 1,763,016.48** | **$ 2,477,311.99** |
| | | | | |
| **Direct Costs** | | | | |
| Salaries - RN | | $ 163,800.00 | $ 280,800.00 | $ 280,800.00 |
| Salaries - LPN | | $ 16,640.00 | $ 66,560.00 | $ 66,560.00 |
| Salaries - HHA (CNA's) | | $ 45,760.00 | $ 137,280.00 | $ 137,280.00 |
| Salaries - Medical Director | | $ 78,000.00 | $ 78,000.00 | $ 78,000.00 |
| Salaries - Spiritual Counseling | | $ 62,400.00 | $ 62,400.00 | $ 62,400.00 |
| Salaries - Volunteer Coordinator | | $ 15,600.00 | $ 15,600.00 | $ 15,600.00 |
| Salaries - Medical Social Worker (MSW) | | $ 54,600.00 | $ 72,800.00 | $ 72,800.00 |
| **TOTAL** | | **$ 436,800.00** | **$ 713,440.00** | **$ 713,440.00** |
| | | | | |
| Payroll Tax | 8% | $ 34,944.00 | $ 57,075.20 | $ 57,075.20 |
| Benefits | 12% | $ 52,416.00 | $ 85,612.80 | $ 85,612.80 |
| Pharmacy | $7/PPD | $ 43,423.38 | $ 67,108.86 | $ 94,303.30 |
| DME | $7/PPD | $ 43,423.38 | $ 67,108.86 | $ 94,303.30 |
| Medical Supplies | $4/PPD | $ 24,813.36 | $ 38,347.92 | $ 53,887.60 |
| Mileage | | $ 17,229.31 | $ 26,627.11 | $ 37,417.19 |
| Other Direct Costs | 3% | $ 34,225.05 | $ 52,890.49 | $ 74,319.36 |
| Respite Costs | | $ 2,000.00 | $ 2,000.00 | $ 2,000.00 |
| Inpatient Costs | | $ 2,000.00 | $ 2,000.00 | $ 2,000.00 |
| **TOTAL DIRECT COST** | | **$ 691,274.48** | **$ 1,112,211.25** | **$ 1,214,358.75** |
| | | | | |
| **GROSS MARGIN** | | **$ 449,560.50** | **$ 650,805.23** | **$ 1,262,953.24** |
| | | | | |
| **Admin Costs** | | | | |
| Salaries - Administrator | | $ 58,240.00 | $ 87,360.00 | $ 116,480.00 |
| Salaries - Business Office Manager | | $ 68,640.00 | $ 68,640.00 | $ 68,640.00 |
| Salaries - Intake Coordinator/Scheduler | | $ 49,920.00 | $ 49,920.00 | $ 49,920.00 |
| Salaries - Sales- Patient Service Rep | | $ 35,360.00 | $ 70,720.00 | $ 106,080.00 |
| Salaries - Clinical Manager | | $ 52,000.00 | $ 104,000.00 | $ 104,000.00 |
| **TOTAL** | | **$ 264,160.00** | **$ 380,640.00** | **$ 445,120.00** |
| | | | | |
| Payroll Tax | 8% | $ 21,194.45 | $ 30,540.03 | $ 35,713.48 |
| Benefits | 12% | $ 31,699.20 | $ 45,676.80 | $ 53,414.40 |
| | | | | |
| **Expenses** | | | | |
| Marketing | | $ 20,000.00 | $ 22,000.00 | $ 24,200.00 |
| Education and Training | | $ 2,500.00 | $ 3,500.00 | $ 5,000.00 |
| Capital Expenditure | | $ 12,500.00 | $ 4,000.00 | $ 10,000.00 |
| IT & Software Maintenance | | $ 5,000.00 | $ 6,000.00 | $ 7,000.00 |
| Home Office Allocation | | $ 57,041.75 | $ 88,150.82 | $ 123,865.60 |
| Licenses and Fees | | $ 13,062.00 | $ 1,856.00 | $ 1,856.00 |
| Purchased Services | | $ 5,000.00 | $ 6,500.00 | $ 8,000.00 |
| Office Supplies | | $ 6,000.00 | $ 6,000.00 | $ 6,000.00 |
| Internet/Phone/Data | | $ 5,000.00 | $ 6,200.00 | $ 7,400.00 |
| Travel | | $ 1,500.00 | $ 1,500.00 | $ 1,500.00 |
| Insurance - Liability | | $ 6,000.00 | $ 6,000.00 | $ 6,000.00 |
| Depreciation | | $ 4,166.67 | $ 5,500.00 | $ 7,500.00 |
| B&O Tax | 2% | $ 22,816.70 | $ 35,260.33 | $ 49,546.24 |
| Rent expense | | $ 8,370.00 | $ 8,370.00 | $ 8,370.00 |
| Interest | | $ 13,280.00 | $ 20,560.00 | $ 20,560.00 |
| **TOTAL EXPENSES** | | **$ 1,190,565.24** | **$ 1,790,465.23** | **$ 2,035,404.46** |
| | | | | |
| **NET INCOME** | | **$ (49,730.26)** | **$ (27,448.75)** | **$ 441,907.53** |
| **NI %** | | **-4%** | **-2%** | **18%** |
| **EBITDA** | | **$ (32,283.59)** | **$ (1,388.75)** | **$ 469,967.53** |
| **EBITDA%** | | **-3%** | **0%** | **19%** |

## Proforma Balance Sheet
### Pierce County Hospice

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| **Assets** | | | |
| **Current Assets** | | | |
| Cash | $ 54,937.66 | $ 89,089.14 | $ 444,528.37 |
| Accounts Receivable | $ 165,655.49 | $ 255,999.65 | $ 359,719.28 |
| Allowance for Bad Debt | $ (5,797.94) | $ (8,959.99) | $ (12,590.17) |
| Pre-paid Expenses | $ 6,697.50 | $ 6,697.50 | $ 6,697.50 |
| **Total Current Assets** | $ 221,492.71 | $ 342,826.31 | $ 798,354.97 |
| **Property and Equipment** | | | |
| Leasehold Improvements | $ - | $ - | $ - |
| Furniture & Equipment | $ 12,500.00 | $ 16,500.00 | $ 26,500.00 |
| Accumulated Depreciation | $ (4,166.67) | $ (9,666.67) | $ (17,166.67) |
| **Total Property & Equipment** | $ 8,333.33 | $ 6,833.33 | $ 9,333.33 |
| **Total Assets** | **$ 229,826.04** | **$ 349,659.64** | **$ 807,688.30** |
| **Liabilities** | | | |
| **Current Liabilities** | | | |
| Line of Credit | $ 166,000.00 | $ 257,000.00 | $ 257,000.00 |
| Accounts Payable | $ 32,025.47 | $ 41,201.94 | $ 54,098.45 |
| Payroll | $ 31,800.57 | $ 51,457.70 | $ 54,682.33 |
| **Total Current Liabilities** | $ 229,826.04 | $ 349,659.64 | $ 365,780.78 |
| **Total Long Term Liabilities** | $ - | $ - | $ - |
| **Total Liabilites** | **$ 229,826.04** | **$ 349,659.64** | **$ 365,780.78** |
| **Equity** | | | |
| Capital Contributions | $ 49,730.26 | $ 77,179.01 | $ 77,179.01 |
| Retained Earnings | $ - | $ (49,730.26) | $ (77,179.01) |
| Net Income | $ (49,730.26) | $ (27,448.75) | $ 441,907.53 |
| **Total Equity** | **$ (0.00)** | **$ (0.00)** | **$ 441,907.53** |
| **Total Liabilities and Equity** | **$ 229,826.04** | **$ 349,659.64** | **$ 807,688.30** |
| **Total Assets - Liabilities & Equity** | **$ -** | **$ (0.00)** | **$ (0.00)** |

# Proforma Cash Flow
## Pierce County Hospice

| | 2022 | 2023 | 2024 |
|---|---|---|---|
| **Cash Flow from Operating Activities** | | | |
| Net Income | $ (49,730.26) | $ (27,448.75) | $ 441,907.53 |
| Add Depreciation | $ 4,166.67 | $ 5,500.00 | $ 7,500.00 |
| | | | |
| Accounts Receivable | $ (165,655.49) | $ (90,344.16) | $ (103,719.62) |
| Accrued AP | $ 32,025.47 | $ 9,176.47 | $ 12,896.51 |
| Accrued Payroll | $ 31,800.57 | $ 19,657.13 | $ 3,224.63 |
| Allowance for Bad Debt | $ 5,797.94 | $ 3,162.05 | $ 3,630.19 |
| Pre-paid Expenses | $ (6,697.50) | $ - | $ - |
| **Total** | $ (148,292.60) | $ (80,297.26) | $ 365,439.23 |
| | | | |
| **Investing Activities** | | | |
| Purchase of Equipment | $ (12,500.00) | $ (4,000.00) | $ (10,000.00) |
| | | | |
| **Financing Activities** | | | |
| Net Borrowing on Line of Credit | $ 166,000.00 | $ 91,000.00 | $ - |
| Capital Contributions | $ 49,730.26 | $ 27,448.75 | $ - |
| | | | |
| **Net Cash** | **$ 54,937.66** | **$ 34,151.49** | **$ 355,439.23** |
| | | | |
| Beginning Cash | $ - | $ 54,937.66 | $ 89,089.14 |
| Cash from Operations | $ (148,292.60) | $ (80,297.26) | $ 365,439.23 |
| Cash from Investing | $ (12,500.00) | $ (4,000.00) | $ (10,000.00) |
| Cash from Financing | $ 215,730.26 | $ 118,448.75 | $ - |
| | | | |
| **Ending Cash** | **$ 54,937.66** | **$ 89,089.14** | **$ 444,528.37** |

**Staffing Details**

| Pierce Hospice | | FTE Count | FTE Count | FTE Count | Cost | Cost | Cost | |
|---|---|---|---|---|---|---|---|---|
| **HCHB's staff to patient ratio (based on ADC)** | | **2022** | **2023** | **2024** | **2022** | **2023** | **2024** | **TOTAL** |
| | **$ Rate/hr** | | | | | | | |
| **Clinical/Direct** | | | | | | | | |
| Salaries - RN | $ 45.00 | 1.75 | 3.00 | 3.00 | $ 163,800.00 | $ 280,800.00 | $ 280,800.00 | $ 725,400.00 |
| Salaries - LPN | $ 32.00 | 0.25 | 1.00 | 1.00 | $ 16,640.00 | $ 66,560.00 | $ 66,560.00 | $ 149,760.00 |
| Salaries - HHA (CNA's) | $ 22.00 | 1.00 | 3.00 | 3.00 | $ 45,760.00 | $ 137,280.00 | $ 137,280.00 | $ 320,320.00 |
| Salaries - Medical Director (Contracted) | $ 150.00 | 0.25 | 0.25 | 0.25 | $ 78,000.00 | $ 78,000.00 | $ 78,000.00 | $ 234,000.00 |
| Salaries - Spiritual Counseling | $ 30.00 | 1.00 | 1.00 | 1.00 | $ 62,400.00 | $ 62,400.00 | $ 62,400.00 | $ 187,200.00 |
| Salaries - Volunteer Coordinator | $ 30.00 | 0.25 | 0.25 | 0.25 | $ 15,600.00 | $ 15,600.00 | $ 15,600.00 | $ 46,800.00 |
| Salaries - Medical Social Worker (MSW) | $ 35.00 | 0.75 | 1.00 | 1.00 | $ 54,600.00 | $ 72,800.00 | $ 72,800.00 | $ 200,200.00 |
| **Total Direct** | | **5.25** | **9.50** | **9.50** | **$ 436,800.00** | **$ 713,440.00** | **$ 713,440.00** | **$ 1,863,680.00** |
| **Administrative** | | | | | | | | |
| Salaries - Administrator | $ 56.00 | 0.50 | 0.75 | 1.00 | $ 58,240.00 | $ 87,360.00 | $ 116,480.00 | $ 262,080.00 |
| Salaries - Business Office Manager | $ 33.00 | 1.00 | 1.00 | 1.00 | $ 68,640.00 | $ 68,640.00 | $ 68,640.00 | $ 205,920.00 |
| Salaries - Intake Coordinator/Scheduler | $ 24.00 | 1.00 | 1.00 | 1.00 | $ 49,920.00 | $ 49,920.00 | $ 49,920.00 | $ 149,760.00 |
| Salaries - Sales- Patient Service Rep | $ 34.00 | 0.50 | 1.00 | 1.50 | $ 35,360.00 | $ 70,720.00 | $ 106,080.00 | $ 212,160.00 |
| Salaries - Clinical Manager | $ 50.00 | 0.50 | 1.00 | 1.00 | $ 52,000.00 | $ 104,000.00 | $ 104,000.00 | $ 260,000.00 |
| **Total Admin** | | **3.50** | **4.75** | **5.50** | **$ 264,160.00** | **$ 380,640.00** | **$ 445,120.00** | **$ 1,089,920.00** |
| **Total Staff** | | **8.75** | **14.25** | **15.00** | **$ 700,960.00** | **$ 1,094,080.00** | **$ 1,158,560.00** | **$ 2,953,600.00** |

**Revenue Assumptions**
**Pierce County Hospice**

| Patient Days by Level of Care | 2022 | 2023 | 2024 | Notes |
|---|---|---|---|---|
| Routine HC 0-60 | 2853.54 | 4410.01 | 6197.07 | *46% of Patient Days* |
| Routine HC 61+ | 3225.74 | 4985.23 | 7005.39 | *52% of Patient Days* |
| Respite Care | 62.03 | 95.87 | 134.72 | *1% of Patient Days* |
| General Inpatient care | 31.02 | 47.93 | 67.36 | *.5% of Patient Days* |
| Continuous Care | 31.02 | 47.93 | 67.36 | *.5% of Patient Days* |
| **Per Patient Day Rates** | | | | |
| Routine HC 0-60 | $ 218.46 | $ 218.46 | $ 218.46 | *See Exhibit 13 for the Washington Hospice Rates* |
| Routine HC 61+ | $ 172.67 | $ 172.67 | $ 172.67 | *See Exhibit 13 for the Washington Hospice Rates* |
| Respite Care | $ 496.11 | $ 496.11 | $ 496.11 | *See Exhibit 13 for the Washington Hospice Rates* |
| General Inpatient care | $ 1,139.57 | $ 1,139.57 | $ 1,139.57 | *See Exhibit 13 for the Washington Hospice Rates* |
| Continuous Care | $ 65.44 | $ 65.44 | $ 65.44 | *See Exhibit 13 for the Washington Hospice Rates* |
| **Gross Revenue by Level of Care** | | | | |
| Routine HC 0-60 | $ 623,383.56 | $ 963,410.96 | $ 1,353,812.79 | *Patient Days x Patient Day Rates* |
| Routine HC 61+ | $ 556,987.97 | $ 860,799.60 | $ 1,209,620.35 | *Patient Days x Patient Day Rates* |
| Respite Care | $ 30,775.39 | $ 47,561.97 | $ 66,835.44 | *Patient Days x Patient Day Rates* |
| General Inpatient care | $ 35,345.70 | $ 54,625.17 | $ 76,760.87 | *Patient Days x Patient Day Rates* |
| Continuous Care | $ 2,029.73 | $ 3,136.86 | $ 4,408.01 | *Patient Days x Patient Day Rates* |
| **Total Gross Revenue** | **$ 1,248,522.36** | **$ 1,929,534.55** | **$ 2,711,437.45** | |

**PRO FORMA ASSUMPTIONS**

**Pierce County Hospice**

| Expenses | Assumptions |
|---|---|
| Admissions | *See explanation in Question A.2.* |
| Visits per patient | *Based on HCHB analytics data for all Oregon Hospice agencies in 2020* |
| Average Length of Stay | *State Determined* |
| Rate per Day | *Total revenue divided by patient days* |
| Patient Days | *Average Length of Stay x Admissions* |
| Average Daily Census | *Patient Days Divided by 365* |
| | |
| Medicare | *95% x Admissions x ALOS x Rate per Day* |
| Managed Medicare | *0% x Admissions x ALOS x Rate per Day* |
| Medicaid | *4% x Admissions x ALOS x Rate per Day* |
| Commercial | *1% x Admissions x ALOS x Rate per Day* |
| **Total Revenue** | |
| **Revenue Reductions** | |
| Sequestration | *2% of Medicare Revenue* |
| Bad Debt | *1% of Total Revenue* |
| Charity | *1% of Total Revenue* |
| | |
| **Net Revenue** | |
| | |
| **Direct Costs** | |
| Salaries - RN | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - LPN | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Clinical Manager | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - HHA (CCNA's) | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Medical Director | *CONTRACT (Hourly Rate x Hours Worked)* |
| Salaries - Spiritual Counseling | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Volunteer Coordinator | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Medical Social Worker (MSW) | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| **Total Direct Salaries** | |
| Payroll Tax | *8% of Total Direct Costs/Salaries* |
| Benefits | *12% of Total Direct Costs/Salaries* |
| Pharmacy | *$7/PPD* |
| DME | *$7/PPD* |
| Medical Supplies | *$4/PPD* |
| Mileage | *11 miles/PPD at 48 cents per mile* |
| Other Direct Costs | *3% of net revenue per year - infusion, ambulance, palliative, and contract labor* |
| Respite Costs | *$2,000/yr* |
| Inpatient Costs | *$2,000/yr* |
| **TOTAL DIRECT COST** | |
| **GROSS MARGIN** | *Net revenue - total direct costs* |
| | |
| **Admin Costs** | |
| Salaries - Administrator | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Business Office Manager | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Intake/Scheduler | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Sales - Patient Service Rep | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| Salaries - Clinical Manager | *FTE x annual compensation (hourly compensation x 2080 hours per year)* |
| **Total Admin Cost** | |
| Payroll Tax | *8% of Total Admin Costs/Salaries* |
| Benefits | *12% of Total Admin Costs/Salaries* |
| **Expenses** | |
| Marketing | *Lump Sum by year for Advertising, promotional materials, dues, public relations. Increasing by 10% for years 2 and 3.* |
| Education and Training | *Lump sun by year for continuing education, seminars, etc.* |
| Capital Expenditure | *Equipment, furniture, replacements for equipment, and misc signage* |
| IT & Software Maintenance | *Lump sum by year for HCHB Maintenence Fees, Forcura, Microsoft licenses* |
| Home Office Allocation | *Management fee of 5% of net revenue, includes accounting, IT, and legal services* |
| Licenses and Fees | *Accreditation for the first year plus initial license costs, then WA license maintenance fees for years 2 and 3* |
| Purchased Services | *Lump sum by year for Contract Labor; music therapy, massage therapy, etc.* |
| Office Supplies | *Lump sum by year for Office supplies - assumed to be $500 per month* |
| Internet/Phone/Data | *Lump sum by year for Land line/ Internet, Efax, cell phone plans/data, and HCHB data* |
| Travel | *Lump sum by year for Lodging/Travel: Includes mileage and any misc travel costs associated with office staff* |
| Insurance - Liability | *Lump sum by year - assumed to be $500/month for liability insurance* |
| Depreciation | *Straight line depreciation* |
| B&O Tax | *2% of Net Revenue* |
| Rent expense | *Straight line rent expense* |
| Interest | *Allocated based on line of credit usage - 8% of the net borrowed or un-used line fee.* |
| | |

| | |
|---|---|
| **Total Expense** | *Sum of admin costs, expenses, and direct costs* |
| | |
| **Net Income** | *Net Revenue - total expenses* |
| **NI %** | |
| **EBITDA** | |
| **EBITDA%** | |
| | |
| **AP** | *Total of respite, inpatient, SNF, contract labor, medical supplies, pharmacy,other direct costs, and expenses and then divided by 12 to account for the 30 day payment schedule* |
| **Payroll** | *Total of salaries, payroll tax, and benefits for each of the 24 payroll periods* |
| | |
| | |
| **BALANCE SHEET ASSUMPTIONS** | |
| **Assets** | |
| **Current Assets** | |
| Cash | |
| Accounts Receivable | *Net Revenue Divided by 365 multipled by 53. We used 53 days based on other Washington DSO numbers.* |
| Allowance for Bad Debt | *3.5% of receivables* |
| Pre-paid Expenses | *Liability insurance and 1/12 of the rent* |
| **Total Current Assets** | |
| | |
| **Property and Equipment** | |
| Leasehold Improvements | |
| Furniture & Equipment | *Our increases year over year is related to revenue growth* |
| Accumulated Depreciation | |
| **Total Property & Equipment** | |
| | |
| **Total Assets** | |
| | |
| **Liabilities** | |
| **Current Liabilities** | |
| Line of Credit | *Amount borrowed* |
| Accounts Payable | *1 month of non-payroll related expenses* |
| Payroll | *24 payroll periods* |
| **Total Current Liabilities** | |
| | |
| **Total Long Term Liabilities** | |
| | |
| **Total Liabilites** | |
| | |
| **Equity** | |
| Capital Contributions | *To cover losses* |
| Retained Earnings | |
| Net Income | |
| **Total Equity** | |
| | |
| **Total Liabilities and Equity** | |
| | |
| **Total Assets - Total Liabilities & Equity** | |
| | |
| | |

## EXHIBIT 13: Washington State Hospice Rates

# National Medicare Hospice Payment Rates

BKD CPAs & Advisors

| | 0651 Routine Home Care | | | 0652 | 0655 | 0656 |
|---|---|---|---|---|---|---|
| | High Rate (1) | Low Rate (2) | Service Intensity Add-on (3)** | Continuous Home Care** | Inpatient Respite Care | General Inpatient Care |
| | *Daily Rate* | *Daily Rate* | *Hourly Rate* | *Daily Rate* | *Daily Rate* | *Daily Rate* |
| National payment rate, before wage-index adjustment, effective October 1, 2020 | $ 199.25 | $ 157.49 | $ 59.68 | $ 1,432.41 | $ 461.09 | $ 1,045.66 |
| Labor share, subject to wage-index adjustment | $ 136.90 | $ 108.21 | $ 41.01 | $ 984.21 | $ 249.59 | $ 669.33 |
| Non-labor share, not subject to wage-index adjustment | $ 62.35 | $ 49.28 | $ 18.67 | $ 448.20 | $ 211.50 | $ 376.33 |
| *% change from prior year* | *2.4%* | *2.5%* | *2.6%* | *2.6%* | *2.4%* | *2.4%* |
| *National payment rate, before wage-index adjustment, effective October 1, 2019* | *$ 194.50* | *$ 153.72* | *$ 58.15* | *$ 1,395.63* | *$ 450.10* | *$ 1,021.25* |
| *Labor share, subject to wage-index adjustment* | *$ 133.64* | *$ 105.62* | *$ 39.96* | *$ 958.94* | *$ 243.64* | *$ 653.70* |
| *Non-labor share, not subject to wage-index adjustment* | *$ 60.86* | *$ 48.10* | *$ 18.19* | *$ 436.69* | *$ 206.46* | *$ 367.55* |

| | |
|---|---|
| Hospice aggregate payment cap for cap year ending September 30, 2021 | $30,683.93 |
| Hospice aggregate payment cap for cap year ended September 30, 2020 | $29,964.78 |

(1) Routine home care (RHC) high rate applies to hospice patients whose services occur during the first 60 calendar days of a hospice episode of care. A hospice episode of care is considered to be continuous unless there has been more than 60 days between hospice discharge and readmission.

(2) RHC low rate applies to hospice patients whose services occur on calendar day 61 or later during a hospice episode of care. A hospice episode of care is considered to be continuous unless there has been more than 60 days between hospice discharge and readmission.

(3) Service intensity add-on (SIA) is paid on visits performed by registered nurses (RNs) or medical social workers (MSW) for patients during the last seven days of life. SIA is paid in 15-minute increments for up to four hours total per day of combined RN and MSW direct visit time and is in addition to the daily RHC rate. SIA does not apply to days paid at the continuous home care, inpatient respite or general inpatient care rates.

All rate information based on the ***Federal Register*** dated August 4, 2020, and the ***Centers for Medicare and Medicaid Services Manual System Pub. 100-04 Medicare Claims Processing Transmittal 10338, Change Request 11876*** dated August 27, 2020.



*Sorted by county or parish
**Hourly rate is paid in 15-minute increments

# Washington Wage-Index Adjusted Medicare Hospice Payment Rates
## *Effective October 1, 2020 Through September 30, 2021*

BKD CPAs & Advisors

| Billing Code | Core-Based Statistical Area | County or Parish* | State | Wage-Index | 0651 Routine Home Care: High Rate (1) Daily Rate | 0651 Routine Home Care: Low Rate (2) Daily Rate | 0651 Routine Home Care: Service Intensity Add-on (3)** Hourly Rate | 0652 Continuous Home Care** Hourly Rate | 0655 Inpatient Respite Care Daily Rate | 0656 General Inpatient Care Daily Rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 30300 | Lewiston | Asotin | WA | 0.8150 | $ 173.92 | $ 137.47 | $ 52.09 | $ 52.10 | $ 414.92 | $ 921.83 |
| | *After 2% reduction for sequestration* | | | | *$ 170.44* | *$ 134.72* | *$ 51.05* | *$ 51.06* | *$ 406.62* | *$ 903.39* |
| | *% change from prior year* | | | *-5.0%* | *-0.9%* | *-0.9%* | *-0.7%* | *-0.7%* | *-0.1%* | *-0.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.8579* | *$ 172.00* | *$ 135.94* | *$ 51.42* | *$ 51.42* | *$ 407.17* | *$ 909.79* |
| 28420 | Kennewick-Richland | Benton | WA | 0.9819 | $ 196.77 | $ 155.53 | $ 58.94 | $ 58.94 | $ 456.57 | $ 1,033.55 |
| | *After 2% reduction for sequestration* | | | | *$ 192.83* | *$ 152.42* | *$ 57.76* | *$ 57.76* | *$ 447.44* | *$ 1,012.88* |
| | *% change from prior year* | | | *1.5%* | *3.5%* | *3.5%* | *3.7%* | *3.7%* | *3.2%* | *3.3%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9676* | *$ 186.37* | *$ 147.29* | *$ 55.72* | *$ 55.72* | *$ 433.37* | *$ 980.07* |
| 48300 | Wenatchee | Chelan | WA | 0.9594 | $ 193.69 | $ 153.10 | $ 58.01 | $ 58.02 | $ 450.96 | $ 1,018.49 |
| | *After 2% reduction for sequestration* | | | | *$ 189.82* | *$ 150.04* | *$ 56.85* | *$ 56.86* | *$ 441.94* | *$ 998.12* |
| | *% change from prior year* | | | *2.1%* | *3.9%* | *3.9%* | *4.0%* | *4.1%* | *3.6%* | *3.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9400* | *$ 182.75* | *$ 144.43* | *$ 54.64* | *$ 54.64* | *$ 426.77* | *$ 962.39* |
| 38900 | Portland-Vancouver-Hillsboro | Clark | WA | 1.2202 | $ 229.40 | $ 181.32 | $ 68.71 | $ 68.71 | $ 516.05 | $ 1,193.05 |
| | *After 2% reduction for sequestration* | | | | *$ 224.81* | *$ 177.69* | *$ 67.34* | *$ 67.34* | *$ 505.73* | *$ 1,169.19* |
| | *% change from prior year* | | | *2.4%* | *4.2%* | *4.2%* | *4.4%* | *4.4%* | *3.9%* | *4.0%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1921* | *$ 215.77* | *$ 170.53* | *$ 64.51* | *$ 64.51* | *$ 486.96* | *$ 1,123.89* |
| 31020 | Longview | Cowlitz | WA | 1.0510 | $ 206.23 | $ 163.01 | $ 61.77 | $ 61.78 | $ 473.82 | $ 1,079.80 |
| | *After 2% reduction for sequestration* | | | | *$ 202.11* | *$ 159.75* | *$ 60.53* | *$ 60.54* | *$ 464.34* | *$ 1,058.20* |
| | *% change from prior year* | | | *-4.4%* | *-0.8%* | *-0.8%* | *-0.6%* | *-0.6%* | *-0.1%* | *-0.6%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.0998* | *$ 203.68* | *$ 160.97* | *$ 60.90* | *$ 60.90* | *$ 464.93* | *$ 1,064.76* |
| 48300 | Wenatchee | Douglas | WA | 0.9594 | $ 193.69 | $ 153.10 | $ 58.01 | $ 58.02 | $ 450.96 | $ 1,018.49 |
| | *After 2% reduction for sequestration* | | | | *$ 189.82* | *$ 150.04* | *$ 56.85* | *$ 56.86* | *$ 441.94* | *$ 998.12* |
| | *% change from prior year* | | | *2.1%* | *3.9%* | *3.9%* | *4.0%* | *4.1%* | *3.6%* | *3.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9400* | *$ 182.75* | *$ 144.43* | *$ 54.64* | *$ 54.64* | *$ 426.77* | *$ 962.39* |

*Sorted by county or parish
**Hourly rate is paid in 15-minute increments

# Washington Wage-Index Adjusted Medicare Hospice Payment Rates

## *Effective October 1, 2020 Through September 30, 2021*

BKD CPAs & Advisors

| Billing Code | Core-Based Statistical Area | County or Parish* | State | Wage-Index | 0651 Routine Home Care High Rate (1) Daily Rate | 0651 Routine Home Care Low Rate (2) Daily Rate | 0651 Routine Home Care Service Intensity Add-on (3)** Hourly Rate | 0652 Continuous Home Care** Hourly Rate | 0655 Inpatient Respite Care Daily Rate | 0656 General Inpatient Care Daily Rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 28420 | Kennewick-Richland | Franklin | WA | 0.9819 | $ 196.77 | $ 155.53 | $ 58.94 | $ 58.94 | $ 456.57 | $ 1,033.55 |
| | *After 2% reduction for sequestration* | | | | *$ 192.83* | *$ 152.42* | *$ 57.76* | *$ 57.76* | *$ 447.44* | *$ 1,012.88* |
| | *% change from prior year* | | | *1.5%* | *3.5%* | *3.5%* | *3.7%* | *3.7%* | *3.2%* | *3.3%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9676* | *$ 186.37* | *$ 147.29* | *$ 55.72* | *$ 55.72* | *$ 433.37* | *$ 980.07* |
| 42644 | Seattle-Bellevue-Everett | King | WA | 1.1767 | $ 223.44 | $ 176.61 | $ 66.93 | $ 66.93 | $ 505.19 | $ 1,163.93 |
| | *After 2% reduction for sequestration* | | | | *$ 218.97* | *$ 173.08* | *$ 65.59* | *$ 65.59* | *$ 495.09* | *$ 1,140.65* |
| | *% change from prior year* | | | *0.4%* | *2.7%* | *2.8%* | *2.9%* | *2.9%* | *2.7%* | *2.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1718* | *$ 213.11* | *$ 168.43* | *$ 63.72* | *$ 63.72* | *$ 482.12* | *$ 1,110.89* |
| 14740 | Bremerton-Silverdale-Port Orchard | Kitsap | WA | 1.1451 | $ 219.11 | $ 173.19 | $ 65.63 | $ 65.63 | $ 497.31 | $ 1,142.78 |
| | *After 2% reduction for sequestration* | | | | *$ 214.73* | *$ 169.73* | *$ 64.32* | *$ 64.32* | *$ 487.36* | *$ 1,119.92* |
| | *% change from prior year* | | | *4.4%* | *5.7%* | *5.7%* | *5.9%* | *5.9%* | *5.0%* | *5.4%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.0964* | *$ 203.23* | *$ 160.62* | *$ 60.76* | *$ 60.76* | *$ 464.12* | *$ 1,062.58* |
| 50023 | Rural Washington | Pend Oreille (Transition) | WA | 1.0554 | $ 206.83 | $ 163.48 | $ 61.95 | $ 61.96 | $ 474.92 | $ 1,082.74 |
| | *After 2% reduction for sequestration* | | | | *$ 202.69* | *$ 160.21* | *$ 60.71* | *$ 60.72* | *$ 465.42* | *$ 1,061.09* |
| | *% change from prior year* | | | *-5.0%* | *-1.2%* | *-1.2%* | *-1.0%* | *-1.0%* | *-0.5%* | *-1.0%* |
| 44060 | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1109* | *$ 205.13* | *$ 162.12* | *$ 61.33* | *$ 61.33* | *$ 467.58* | *$ 1,071.88* |
| 45104 | Tacoma-Lakewood | Pierce | WA | 1.1403 | $ 218.46 | $ 172.67 | $ 65.43 | $ 65.44 | $ 496.11 | $ 1,139.57 |
| | *After 2% reduction for sequestration* | | | | *$ 214.09* | *$ 169.22* | *$ 64.12* | *$ 64.13* | *$ 486.19* | *$ 1,116.78* |
| | *% change from prior year* | | | *-1.4%* | *1.4%* | *1.4%* | *1.6%* | *1.6%* | *1.6%* | *1.4%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1561* | *$ 211.05* | *$ 166.81* | *$ 63.10* | *$ 63.10* | *$ 478.37* | *$ 1,100.82* |
| 34580 | Mount Vernon-Anacortes | Skagit | WA | 1.0011 | $ 199.40 | $ 157.61 | $ 59.73 | $ 59.73 | $ 461.36 | $ 1,046.40 |
| | *After 2% reduction for sequestration* | | | | *$ 195.41* | *$ 154.46* | *$ 58.54* | *$ 58.54* | *$ 452.13* | *$ 1,025.47* |
| | *% change from prior year* | | | *4.2%* | *5.4%* | *5.4%* | *5.6%* | *5.6%* | *4.7%* | *5.1%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9606* | *$ 185.45* | *$ 146.57* | *$ 55.45* | *$ 55.45* | *$ 431.69* | *$ 975.58* |

*Sorted by county or parish

**Hourly rate is paid in 15-minute increments

# Washington Wage-Index Adjusted Medicare Hospice Payment Rates

## *Effective October 1, 2020 Through September 30, 2021*

BKD CPAs & Advisors

| Billing Code | Core-Based Statistical Area | County or Parish* | State | Wage-Index | 0651 Routine Home Care High Rate (1) Daily Rate | 0651 Routine Home Care Low Rate (2) Daily Rate | 0651 Routine Home Care Service Intensity Add-on (3)** Hourly Rate | 0652 Continuous Home Care** Hourly Rate | 0655 Inpatient Respite Care Daily Rate | 0656 General Inpatient Care Daily Rate |
|---|---|---|---|---|---|---|---|---|---|---|
| 38900 | Portland-Vancouver-Hillsboro | Skamania | WA | 1.2202 | $ 229.40 | $ 181.32 | $ 68.71 | $ 68.71 | $ 516.05 | $ 1,193.05 |
| | *After 2% reduction for sequestration* | | | | *$ 224.81* | *$ 177.69* | *$ 67.34* | *$ 67.34* | *$ 505.73* | *$ 1,169.19* |
| | *% change from prior year* | | | *2.4%* | *4.2%* | *4.2%* | *4.4%* | *4.4%* | *3.9%* | *4.0%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1921* | *$ 215.77* | *$ 170.53* | *$ 64.51* | *$ 64.51* | *$ 486.96* | *$ 1,123.89* |
| 42644 | Seattle-Bellevue-Everett | Snohomish | WA | 1.1767 | $ 223.44 | $ 176.61 | $ 66.93 | $ 66.93 | $ 505.19 | $ 1,163.93 |
| | *After 2% reduction for sequestration* | | | | *$ 218.97* | *$ 173.08* | *$ 65.59* | *$ 65.59* | *$ 495.09* | *$ 1,140.65* |
| | *% change from prior year* | | | *0.4%* | *2.7%* | *2.8%* | *2.9%* | *2.9%* | *2.7%* | *2.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1718* | *$ 213.11* | *$ 168.43* | *$ 63.72* | *$ 63.72* | *$ 482.12* | *$ 1,110.89* |
| 44060 | Spokane-Spokane Valley | Spokane | WA | 1.1045 | $ 213.56 | $ 168.80 | $ 63.97 | $ 63.97 | $ 487.17 | $ 1,115.60 |
| | *After 2% reduction for sequestration* | | | | *$ 209.29* | *$ 165.42* | *$ 62.69* | *$ 62.69* | *$ 477.43* | *$ 1,093.29* |
| | *% change from prior year* | | | *-0.6%* | *2.0%* | *2.0%* | *2.2%* | *2.2%* | *2.1%* | *2.0%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1109* | *$ 205.13* | *$ 162.12* | *$ 61.33* | *$ 61.33* | *$ 467.58* | *$ 1,071.88* |
| 44060 | Spokane-Spokane Valley | Stevens | WA | 1.1045 | $ 213.56 | $ 168.80 | $ 63.97 | $ 63.97 | $ 487.17 | $ 1,115.60 |
| | *After 2% reduction for sequestration* | | | | *$ 209.29* | *$ 165.42* | *$ 62.69* | *$ 62.69* | *$ 477.43* | *$ 1,093.29* |
| | *% change from prior year* | | | *-0.6%* | *2.0%* | *2.0%* | *2.2%* | *2.2%* | *2.1%* | *2.0%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1109* | *$ 205.13* | *$ 162.12* | *$ 61.33* | *$ 61.33* | *$ 467.58* | *$ 1,071.88* |
| 36500 | Olympia-Lacey-Tumwater | Thurston | WA | 1.1363 | $ 217.91 | $ 172.24 | $ 65.27 | $ 65.27 | $ 495.11 | $ 1,136.89 |
| | *After 2% reduction for sequestration* | | | | *$ 213.55* | *$ 168.80* | *$ 63.96* | *$ 63.96* | *$ 485.21* | *$ 1,114.15* |
| | *% change from prior year* | | | *-1.0%* | *1.7%* | *1.7%* | *1.9%* | *1.9%* | *1.8%* | *1.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.1482* | *$ 210.02* | *$ 165.98* | *$ 62.79* | *$ 62.79* | *$ 476.49* | *$ 1,095.77* |
| 47460 | Walla Walla | Walla Walla | WA | 1.0795 | $ 210.13 | $ 166.09 | $ 62.94 | $ 62.94 | $ 480.93 | $ 1,098.87 |
| | *After 2% reduction for sequestration* | | | | *$ 205.93* | *$ 162.77* | *$ 61.68* | *$ 61.68* | *$ 471.31* | *$ 1,076.89* |
| | *% change from prior year* | | | *1.9%* | *3.8%* | *3.8%* | *4.0%* | *4.0%* | *3.5%* | *3.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.0593* | *$ 198.37* | *$ 156.78* | *$ 59.31* | *$ 59.31* | *$ 455.26* | *$ 1,038.81* |

*Sorted by county or parish

**Hourly rate is paid in 15-minute increments

# Washington Wage-Index Adjusted Medicare Hospice Payment Rates

## *Effective October 1, 2020 Through September 30, 2021*

BKD CPAs & Advisors

| Billing Code | Core-Based Statistical Area | County or Parish* | State | Wage-Index | 0651 Routine Home Care: High Rate (1) *Daily Rate* | 0651 Routine Home Care: Low Rate (2) *Daily Rate* | 0651 Routine Home Care: Service Intensity Add-on (3)** *Hourly Rate* | 0652 Continuous Home Care** *Hourly Rate* | 0655 Inpatient Respite Care *Daily Rate* | 0656 General Inpatient Care *Daily Rate* |
|---|---|---|---|---|---|---|---|---|---|---|
| 13380 | Bellingham | Whatcom | WA | 1.2149 | $ 228.67 | $ 180.74 | $ 68.49 | $ 68.50 | $ 514.73 | $ 1,189.50 |
| | *After 2% reduction for sequestration* | | | | *$ 224.10* | *$ 177.13* | *$ 67.12* | *$ 67.13* | *$ 504.44* | *$ 1,165.71* |
| | *% change from prior year* | | | *0.5%* | *2.8%* | *2.8%* | *3.0%* | *3.0%* | *2.7%* | *2.7%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.2089* | *$ 217.97* | *$ 172.26* | *$ 65.17* | *$ 65.17* | *$ 490.98* | *$ 1,134.65* |
| 49420 | Yakima | Yakima | WA | 0.9453 | $ 191.76 | $ 151.57 | $ 57.44 | $ 57.44 | $ 447.44 | $ 1,009.05 |
| | *After 2% reduction for sequestration* | | | | *$ 187.92* | *$ 148.54* | *$ 56.29* | *$ 56.29* | *$ 438.49* | *$ 988.87* |
| | *% change from prior year* | | | *-5.0%* | *-1.1%* | *-1.1%* | *-0.9%* | *-0.9%* | *-0.3%* | *-0.9%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *0.9950* | *$ 189.95* | *$ 150.13* | *$ 56.79* | *$ 56.79* | *$ 439.90* | *$ 997.62* |
| 99950 | Rural Washington | All Other Counties | WA | 1.0292 | $ 203.25 | $ 160.65 | $ 60.88 | $ 60.88 | $ 468.38 | $ 1,065.20 |
| | *After 2% reduction for sequestration* | | | | *$ 199.19* | *$ 157.44* | *$ 59.66* | *$ 59.66* | *$ 459.01* | *$ 1,043.90* |
| | *% change from prior year* | | | *1.1%* | *3.2%* | *3.2%* | *3.4%* | *3.4%* | *3.1%* | *3.1%* |
| | *Prior year comparison, after 2% reduction for sequestration* | | | *1.0179* | *$ 192.95* | *$ 152.50* | *$ 57.69* | *$ 57.69* | *$ 445.37* | *$ 1,012.29* |

*Sorted by county or parish

**Hourly rate is paid in 15-minute increments

## EXHIBIT 14: Medical Director Letter and Draft Agreement

SIGNATURE healthcare at home
care where you are

January 13, 2021

Re: Pierce County Medical Director Contract

Signature Hospice Pierce, LLC and Swenson Healthcare, PLLC have agreed to the terms of the Medical Director Agreement in the form attached hereto and both parties agree that if Signature Hospice Pierce, LLC is approved for a Certificate of Need in Pierce County that the Medical Director Agreement will be fully executed. Dr. Floyd Sekeramayi will serve as the medical director pursuant to Exhibit A of the Medical Director Agreement.

If the application is not approved, the Medical Director Agreement will be null and void.

The signatures below acknowledge the understanding of the agreement and statement above.

DocuSigned by:
Mary Kofstad
73A96D5B1B014F9...

Signature Hospice Pierce, LLC
Mary Kofstad, President

Medical Director
Dr. Floyd Sekeramayi

Swenson Healthcare, PLLC
Darren Swenson, CEO

# Medical Director Agreement

Signature Hospice Pierce, LLC d/b/a
Signature Healthcare at Home

and

Swenson Healthcare, PLLC

# Medical Director Agreement

This Medical Director Agreement (this "agreement"), dated as of the 15th day of January 2021, is made and entered into and by Signature Hospice Pierce, LLC dba Signature Healthcare at Home ("HOSPICE" ) and Swenson Healthcare, PLLC ("PHYSICIAN GROUP").

## RECITALS

A. HOSPICE is the operator of a hospice agency that is Medicare certified and licensed by the state of Washington and is required by the terms of its license and participation agreement with the Medicare program to engage physicians to deliver professional medical direction and clinical services for the benefit of its patients.

B. HOSPICE has determined that this agreement should facilitate maintaining the quality and containing the cost of health care rendered to patients of Hospice and increase administrative management efficiency.

C. PHYSICIAN GROUP has arrangements with physicians who are qualified to provide the medical director services required by HOSPICE, who are duly licensed to practice medicine in the State of Washington and who are qualified, skilled and experienced in providing end-of- life services to terminally ill patients.

D. The parties desire to enter into this Agreement in order to provide for the medical direction of the HOSPICE according to usual and customary national standards, to provide for the uniform application of hospice care procedures, to permit availability and accessibility of physicians for hospice care serves, to provide for educational and administrative services in the HOSPICE, and to promote the economic welfare of the Hospice, all with a view toward maintaining the quality of patient care at the HOSPICE.

E. PHYSICIAN GROUP and DIRECTOR (as herein defined) is willing to accept this Agreement and to undertake the responsibility of providing the services of a medical director required by the HOSPICE in accordance with recognized medical standards and upon the terms and conditions set forth herein.

## AGREEMENT

In consideration of the mutual promises of the parties herein, and of the covenants and conditions hereinafter expressed, the parties hereby covenant, each with the other, as follows:

1. **Appointment of Director**. PHYSICIAN GROUP shall designate a physician to act as a medical director for HOSPICE by completing the delivering to HOSPICE a Physician appointment Form attached hereto as Exhibit A and incorporated herein by reference ("Physician Appointment Form"). In the event PHYSICIAN GROUP seeks to

replace an existing DIRECTOR, such replacement shall be subject to HOSPICE's approval which HOSPICE may withhold in its sole discretion. PHYSICIAN GROUP agrees to designate a new physician to act as DIRECTOR within three (3) business days of HOSPICE's request. The physician named in the most current fully executed Physician Appointment Form shall be referred to as "DIRECTOR" for purposes of this Agreement.

2. **Obligations of Director and Physician Group.** PHYSICIAN GROUP on behalf of itself and the DIRECTOR agrees as follows:

2.1 Medical Director Responsibilities. DIRECTOR will direct and supervise the clinical operations of the HOSPICE assuming overall responsibility for the medical component of the patient care as required by the Medicare Conditions of Participation for the hospice care. 42 C.F.R. Part 418, and the job description contained in Signature's Policies and Procedures manual attached as Exhibit B, which job description may be amended from time to time. In addition to the forgoing, during the term of this Agreement, DIRECTOR will do the following:

A. Supervise, evaluate and be responsible for the standards and overall quality of the hospice care services rendered to patients by physicians through the HOSPICE;

B. Attend and participate in all scheduled interdisciplinary team meetings or secure the attendance of an alternate physician approved by HOSPICE;

C. Review the clinical activities of all non-physician staff within the HOSPICE, and consult with HOSPICE as requested to help assure that the work of such non-physician personnel is satisfactorily performed;

D. As reasonably requested, attend and represent the HOSPICE at meetings of HOSPICES's committees and community organizations;

E. Coordinate and participate in HOSPICE's quality assurance activities to assure the adequacy and safety of hospice services rendered at the HOSPICE;

F. Provide consultation concerning the delivery of hospice services, and assist in obtaining other required professional consultation;

G. Develop guidelines for selecting individual practitioners qualified to exercise clinical privileges at the HOSPICE; and

H. Recommend equipment and supplies necessary for the proper functioning of the HOSPICE.

The parties anticipate that DIRECTOR's delivery of the medical director services described in this Agreement shall require 5 to 12 hours per week. (ie: 5 hours office time, 1 IDT or stand-up meeting per week, average of 2 patient visits per week, 24 hour on-call coverage, phone consultation and any additional meetings

as needed). PHYSICIAN GROUP may contract to provide other clinical or medical-administrative services as it deems appropriate, so long as such services do not overburden DIRECTOR or interfere with the performance of the DIRECTOR's duties hereunder. PHYSICIAN GROUP shall notify HOSPICE in writing if the DIRECTOR undertakes any other medical-administrative duties.

2.2 Patient Services. DIRECTOR may also be available to undertake and be responsible for the provision of medical services to HOSPICE patients who do not have an attending physician or for whom immediate medical attention is needed and the patient's attending physician is unavailable, including home visits at the request of Hospice Team.

2.3 Education. DIRECTOR shall participate for reasonable periods of time in the educational programs conducted by HOSPICE and shall perform such other teaching functions with HOSPICE as HOSPICE reasonably deems necessary to assure HOSPICE's compliance with requirements of accrediting bodies and to accomplish continually improving quality assurance with the HOSPICE.

2.4 Compliance with Law. The provision of services hereunder shall be in accordance with all applicable laws, rules, regulations and standards of any governmental authority relating to the activities contemplated by this Agreement, including the standards, rules and regulations of the Joint Commission on Accreditation of Healthcare Organizations, the Oregon Department of Health, the Health Care Financing Administration and all other entities having jurisdiction.

2.5 Referrals. HOSPICE and PHYSICIAN GROUP anticipate that the quality and cost-effective nature of the services provided by the facilities and other entities which are affiliated with HOSPICE will commend themselves to the patients of PHYSICIAN GROUP and/or DIRECTOR. However, HOSPICE, PHYSICIAN GROUP and DIRECTOR clearly understand and acknowledge that the choice of services and the choice of service providers made by the patients of PHYSICIAN GROUP or DIRECTOR must be, and will be, made only with regard to the best interests of each patient. Therefore, so there will be no misunderstanding, HOSPICE specifically assures PHYSICIAN GROUP and DIRECTOR, and PHYSICIAN GROUP and DIRECTOR hereby specifically acknowledges, that the performance by HOSPICE of its obligations hereunder in no way obligates, and is in no way contingent upon, the admission, recommendation, referral or any other form or arrangement by PHYSICIAN GROUP or DIRECTOR for utilization by patients or others of any item or service is offered by the facilities or other entities affiliated with HOSPICE.

2.6 Reimbursement. Each party shall cooperate with the other and their respective employees as reasonably requested in the completion of any necessary forms for third party reimbursement.

2.7 Medicare and Medicaid. DIRECTOR agrees to abide by, operate in compliance with and provide services in accordance with applicable Medicare and Medicaid standards for the appropriate condition of participation.

2.8 Quality Assurance Plan. DIRECTOR agrees to cooperate with HOSPICE in connection with any quality assurance and quality management plan with which HOSPICE is involved.

2.9 Policies and Procedures. To ensure the highest quality of medical care in the HOSPICE, DIRECTOR shall consult with HOSPICE and, if requested, prepare and submit to the appropriate HOSPICE committee (and HOSPICE's Board of Directors, if appropriate ) for approval, written policies, procedures and regulations which shall be followed by all physicians practice medicine in the HOSPICE. The policies, procedures and regulations promulgated by HOSPICE shall be enforced by HOSPICE and shall be reviewed and revised periodically in the light of experience and the advancements in medical practice.

2.10 Director is responsible for the submission to Hospice of documentation of services provided as appropriate.

2.11 Personal Expenses. Except as otherwise provided herein, DIRECTOR shall be responsible for all of his personal expenses and professional expenses, such as, but not limited to membership fees, dues and expenses of attending conventions and meetings.

2.12 Taxes. PHYSICIAN GROUP shall be solely responsible for the payment and/or withholding of all applicable federal, state and local income taxes, employment taxes, gross receipt taxes, and FICA, Medicare and unemployment taxes pertaining or attribute to any income or payroll resulting to DIRECTOR or PHYSICIAN GROUP from or attributable to the provision of the services under this Agreement. PHYSICIAN GROUP herby agrees to indemnify HOSPICE, including indemnity for attorneys' fees, from any claims or causes of action arising from the failure of PHYSICIAN GROUP to fulfill such obligations.

2.13 Conflict of Interest. PHYSICIAN GROUP represents that it has advised HOSPICE in writing prior to the date of this Agreement of any relationship with any third party, including without limitation, competitors of HOSPICE which would present a conflict of interest with the performance of DIRECTOR's duties under this Agreement, prevent the carrying out of the terms of this Agreement, or present any opportunity for the disclosure of confidential information of HOSPICE. PHYSICIAN GROUP shall advise HOSPICE of any such relationships that arise during the term of this agreement.

2.14 Clinical Services Revenue. PHYSICIAN GROUP shall be solely responsible for billing Hospice the attending physician services rendered to patients of HOSPICE, and the collections received from the responsible payors shall be HOSPICE's sole compensation for such services. Under no circumstances shall PHYSICIAN GROUP or DIRECTOR seek to collect compensation from patients for medical-administrative services rendered pursuant to this Agreement.

## 3. Hospice's Obligations

3.1 Personnel Provided by HOSPICE. HOSPICE shall make available, or cause to be made available, during the term of this Agreement such professional, technical and support personnel as DIRECTOR shall reasonably require for the performance of his/her duties under this Agreement. The direction and control of such personnel in professional medical matters shall rest with DIRECTOR, however, the selection, retention, direction and control of such personnel in administrative matters shall at all times rest with HOSPICE. Such personnel shall be employees or independent contractors of HOSPICE for purposes of taxes and benefits; they shall not be considered employees of DIRECTOR.

3.2 Space/Equipment. HOSPICE will provide such space and equipment as are reasonably required for the operation of the HOSPICE.

3.3 Orientation. HOSPICE will provide DIRECTOR with an orientation to the hospice program. Additional informational materials will be provided as needed throughout the term of agreement.

3.4 Fee. In consideration of the services of DIRECTOR, HOSPICE shall pay PHYSICIAN GROUP a fee of $150 per hour, payable monthly within forty five (45) days following the receipt of a written report in the form attached hereto as Exhibit C detailing the hours worked, time spent and work performed pursuant for this Agreement during the prior month.

## 4. Education/vacation.

4.1 Scientific Meetings. DIRECTOR shall have reasonable opportunity and is expected to attend appropriate scientific meetings at DIRECTOR's expense, provided such does not unreasonably interfere with performance of the obligations of DIRECTOR hereunder. If DIRECTOR attends such a meeting at the request of HOSPICE, HOSPICE will reimburse DIRECTOR the actual and reasonable expenses incurred by DIRECTOR in attending such meeting.

4.2 Vacation. DIRECTOR shall be entitled to vacations provided DIRECTOR makes arrangements for adequate coverage during such absence(s) at no additional expense to HOSPICE.

4.3 Notice of Absence(s). DIRECTOR shall notify HOSPICE at least forty-eight (48) hours in advance of any planned absence of DIRECTOR. HOSPICE acknowledges that unplanned emergencies may require DIRECTOR to be absent without notice to HOSPICE.

## 5. Term and Termination

5.1 Term. This Agreement shall remain in full force and effort for a term of one (1) year (the "Primary Term") from and after the Effective Date, and subject to the provisions of Sections 4.1 through 4.5, below, from year to year thereafter until

either party, with or without cause, gives the other written notice of termination at least sixty (60) days prior to the end of the Primary Term.

5.2 Termination without Cause. Either party may terminate this Agreement, with or without cause, at any time by providing to the other party at least sixty (60) days prior written notice of termination. In the event this Agreement is terminated under this Section 4.2, the parties agree that they shall not enter into another agreement covering substantially the same services for at least twelve (12) months following the termination date.

5.3 Termination for Default. If either party defaults in the performance of its obligations under this Agreement and such default is not cured within thirty (30) days of the receipt of written notice thereof, then the non-defaulting party shall have the right, in addition to any other rights it may have, by further written notice to terminate this Agreement on any further date not less than ten (10) days from the date of such further notice.

5.4 Termination by HOSPICE. Notwithstanding the foregoing, HOSPICE shall have the right, in its sole discretion, to terminate this Agreement, in whole or in part, upon the occurrence of any of the following:

A. the revocation, suspension of other material modification or restriction of DIRECTOR's license to practice medicine in the State of Washington or any medical staff membership or privileges of DIRECTOR, or the resignation of DIRECTOR from any hospital's medical staff while under the threat of disciplinary action;

B. the revocation, suspension or material modification or restriction of DIRECTOR's authority issued by any state or federal agency to prescribe dangerous drugs or controlled substances;

C. DIRECTOR's failure to maintain professional liability insurance in the amounts required by this Agreement;

D. DIRECTOR's suspension or termination (whether voluntary or involuntary) of participation in the Medicare or Medicaid programs;

E. Conviction of DIRECTOR of any crime or moral turpitude, including without limitation, fraud or abuse of any payor program;

PHYSICIAN GROUP shall notify HOSPICE within two (2) business days of the occurrence or any of the events set forth in subparts (A)-(E) above.

5.5 Termination For Violation of Applicable Law. If this Agreement is believed to present a material risk of violating any applicable statute, or any applicable regulation or rule promulgated by a federal or state agency, including without limitation, the Internal Revenue Services or the Office of Inspector General of the Department of Health and Human Services, then upon written notice from either

party to the other, the parties agree to use best efforts to renegotiate this Agreement within thirty (30) das of such notice, so as to bring the Agreement into compliance with applicable law, failing which, this Agreement may be terminated by either party upon written notice to the other party.

## 6. Insurance

6.1 Director. PHYSICIAN GROUP shall maintain in force professional liability insurance covering DIRECTOR, with limits of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

6.2 Hospice. HOSPICE shall maintain in force comprehensive professional and general liability insurance covering itself, with limits of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate. In addition, HOSPICE shall maintain in force professional liability insurance covering DIRECTOR while acting within the scope of his administrative duties and clinical responsibilities for HOSPICE pursuant to the terms and provisions of this Agreement, with limits of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

## 7. Miscellaneous

7.1 Relationships of Parties. In the performance of the professional services and responsibilities assumed by DIRECTOR under this Agreement, it is mutually understood and agreed that DIRECTOR is, and at all times shall be, an independent contractor. DIRECTOR shall perform services hereunder in a manner consistent with currently approved methods and practices in the medical profession and otherwise provided in this Agreement. Neither DIRECTOR nor any other persons contracting with DIRECTOR for the delivery of services hereunder are employees of HOSPICE. Nothing contained herein shall be construed to entitle DIRECTOR (or any physician assigned by PHYSICIAN GROUP to deliver services) to any benefits made available to employees of HOSPICE, including without limitation, participation in HOSPICE's retirement and medical plans, or the payment by HOSPICE of any such persons' professional membership fees, dues, or expenses.

7.2 Patient Complaints. The parties agree to cooperate with each other in the resolution of any patient complaints arising out of the services provided hereunder. All complaints shall be resolved in accordance with the procedures established by HOSPICE.

7.3 Remedies. The remedies provided to the parties by this Agreement are no exclusive or exhaustive, but are cumulative of each other and in addition to any other remedies the parties may have.

7.4 Notices. Notices ore communications given under this Agreement shall be given to the respective parties in writing either by personal delivery, overnight delivery service or registered or certified mail, postage prepaid, as follows:

If to HOSPICE: Signature Hospice Pierce, LLC
25117 SW Parkway Drive, Suite F
Wilsonville, OR 97070
Attn: Division President

If to DIRECTOR: Swenson Healthcare, PLLC
1201 Pacific Avenue, Suite 400
Tacoma, WA 98402

or at such other addresses and to such other persons as either party may from time to time designate by notice given as herein provided. Such notices or communications shall be deemed to have been given three (3) days after deposit in the United States mail if sent by regular, registered or certified mail, postage prepaid, or one (1) day after delivery to an overnight delivery service.

7.5 Binding Effect. This agreement shall be binding upon and inure to the benefit of the parties hereto, their successors and assigns and nothing in this Agreement in intended, nor shall be deemed, to confer any benefits on any third party.

7.6 Assignment. This Agreement is to be construed to be a professional service agreement, and no party may assign any of its rights or delegate any of its obligations hereunder without the prior written consent of the non-assigning party.

7.7 Governing Law. This Agreement shall be construed and governed according to the laws of the State of Washington, without giving effect to its conflict of laws provisions.

7.8 Waiver. Waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any prior, concurrent or subsequent breach. None of the provisions of this Agreement shall be considered waived by either party except when such waiver is given in writing.

7.9 Access to Records. DIRECTOR recognizes that HOSPICE is a participant in various third-party payment programs, including, without limitation, Medicare and Medicaid, which participation is essential to the financial viability of HOSPICE. Therefore, in connection with the subject matter of this Agreement, DIRECTOR agrees to fully cooperate with HOSPICE and assist HOSPICE in meeting requirements for participation and payment associated with such third-party payment programs, including, without limitation, the matters more specifically discussed below. In order to assure that payment is made to PHYSICIAN GROUP by or on behalf of HOSPICE pursuant to this Agreement or included to the extent appropriate in determining the reasonable cost incurred by HOSPICE as a provider of service under the Medicare program, PHYSICIAN GROUP agrees that if this Agreement is a contract between the provider and any

of its subcontractors which is entered into after December 5, 1980, and the value or cost of which $10,00.00 or more over a twelve-month period, DIRECTOR will perform the allocations as may be from time to time specified for subcontractors in the Social Security Act § 1861(v)(1)(1) and the regulations promulgated in implementation there of (initially codified at 42 C.F.R. § 420.300 et seq.)

In addition, PHYSICIAN GROUP agrees to make available to HOSPICE such information and records as HOSPICE may reasonably request to facilitate HOSPICE's compliance with the requirements of the Medicare Conditions or Participation and the Medicaid State Plan and to facilitate HOSPICE's substantiation of its reasonable cost in accordance with the requirements applicable to HOSPICE pursuant to Medicare and Medicaid programs including, without limitation, the requirements contained in 42 C.F.R. §, subpt. D; 42 C.F.R. and 42

7.10 Entire Agreement. This Agreement, any amendments or addenda hereto, and any exhibits specifically mentioned herein constitute the entire agreement between the parties regarding the medical direction of the HOSPICE and supersede all prior contemporaneous discussions, representations, correspondence and agreements, whether oral or written, pertaining hereto. This Agreement may be amended or modified only by a writing duly executed by both parties. The language of this Agreement shall be construed as a whole according to its fair and common meaning and shall not be construed for or against either of the parties hereto.

7.11 Attorneys' fees. If either party brings an action against the other to enforce any condition or covenant of this Agreement, the prevailing party shall be entitled to recover its court costs and reasonable attorneys' fees incurred in such action.

7.12 Severability. If any term or provision of this Agreement is held invalid or unenforceable to any extent, the remainder of this Agreement shall not be affected thereby and each term and provision of this Agreement shall be valid and enforceable to the fullest extent permitted by law.

7.13 Agreement Subject to State and Federal Law. The parties recognize that this Agreement at all times in subject to applicable state, local and federal law, including, but not limited to, the Social Security Act and the rules and regulations and policies of the State Department of Health. The parties further recognize that this Agreement shall be subject to amendments of such laws and regulations and to new legislation. Any provisions of law that invalidate, or otherwise are inconsistent with, the terms of this Agreement, or that would cause any of the parties to be in violation of the law, shall be deemed to supersede the terms of this Agreement unless and until the parties come to an agreement on an alternate arrangement pursuant to Section 4.

7.14 Confidentiality. All parties agree to keep this Agreement and its content confidential and not to disclose this Agreement or its contents to any third party, except as required by law, without the written consent of the other party.

Further, DIRECTOR acknowledges and agrees that he will have access to certain confidential information of HOSPICE and that such information constitutes valuable, special and unique property of HOSPICE. DIRECTOR will not, during the term of this Agreement or thereafter, disclose any such confidential information to any other person, firm, or corporation, association or other entity for any other reason or purpose other than the fulfillment of his duties hereunder except as may be required by the order of a court of competent jurisdiction or a governmental agency having the authority to compel such disclosure. HOSPICE shall be entitled to injunctive relief or any other remedy available at law or equity as it elects, in the even that DIRECTOR breaches this duty of confidentiality.

7.15 Survival of Representations. The representations and warranties set forth in this Agreement shall be continuing and shall survive the termination of this Agreement.

7.16 Further Acts. The parties each agree to cooperate fully with the other party to take such further action and execute such other documents or instruments as necessary or appropriate to implant this Agreement.

IN WITNESS HEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

**HOSPICE:**

By:_____
(Signature)

Printed Name: Mary Kofstad
Title: President

**PHYSICIAN GROUP:**

By:_____
(Signature)

Printed Name: Darren Swenson
Title: CEO

**EXHIBIT A**
**PHYSICIAN APPOINTMENT FORM**

Swenson Healthcare, PLLC ("Physician Group") hereby designates the following physician to act as Medical Director pursuant to the terms of the Medical Director Agreement between Physician Group and Signature Hospice Pierce, LLC (Hospice) dated January ___, 2021 ("Agreement"):

_____ ("Physician")

DATED this ____ day of _____, 20____.

By signature hereon Physician consents to his/her appointment as Medical Director and agrees to provide the services and comply with the terms and conditions set forth in the Agreement.

_____
Physician

By signature hereon, the Hospice Administrator consent to the appointment of Physician as Medical Director.

_____
Administrator

EXHIBIT B

Copy of Current Job Description for Medical Director

From Policies and Procedures Manual

(Subject to revision)

**JOB TITLE/POSITION:** Hospice Medical Director

**REPORTS TO:** **Administrator**

## JOB DESCRIPTION SUMMARY:

The Hospice Medical Director will direct and supervise the clinical operations of the assigned Hospice agency(ies) assuming overall responsibility for the medical component of the patient care. He/she is responsible for providing clinical leadership and expertise to the hospice IDG for the purpose of improving patient medical care and palliation. The role is responsible for facilitating a culture of collaboration among all medical and nursing staff involved with hospice patient care.

The Hospice Medical Director will be dedicated to the Mission, Values and Care Commitments of SIGNATURE HOSPICE and embrace and demonstrate our mission: "To Enhance the Life of Every Person We Serve."

## ESSENTIAL JOB FUNCTIONS / RESPONSIBILITIES:

- Reviews, coordinates and oversees the management of the medical services for a hospice program and care for hospice patients, which includes, but is not limited to, medical diagnosis, prognosis, medications, procedures and clinical course.
- Supervises and provides guidance for services provided by other hospice physicians under contract or employed by the agency.
- Provides consultation for palliative and end-of-life care issues.
- Reviews patient eligibility for services including admission and recertification.
- Facilitates communications and works effectively between Signature Hospice employees/volunteers, patients/families/caregivers, physicians, vendors, and other departments, and professionals as appropriate.
- Reviews and evaluates cases through a variety of means such as home visits, conferences, and record reviews; consults with patient's attending physician as needed and appropriate.
- Provides hospice services directly to patients in the patient's home or other setting, including, but not limited to, a nursing facility, assisted living facility, residential care facility, or adult foster home, that is considered to be the patient's home and/or in a hospice in-patient facility, as needed and appropriate.
- Completes, maintains and submits/synchronizes accurate and relevant clinical notes and electronic documents regarding patient's condition and care given. Records pain/symptom management changes/outcomes as appropriate.
- Reviews and signs medication/procedure orders, certification/re-certification of terminal illness orders, changes in level of care and any other supplemental orders as indicated and allowed/required by State and Federal guidelines
- Maintains comprehensive working knowledge of State and federal medical practice regulations and hospice standards; serves as a resource for appropriate organization personnel and community medical personnel.
- Be responsible for assuring that established policies, by-laws, rules and regulations of the organization are followed in the program.
- Assists and supports QAPI committee with identifying quality indicators, proposing

implementation of programs to address identified indicators and evaluating and monitoring outcome measures for effective care.
- Reviews, accepts and abides by the Signature Hospice Medical Staff By-Laws.
- Adheres to all policies, standards and State and federal regulations regarding patient care, conduct, safety, infection control, fire, security and risk management.
- Performs in a cost-effective manner with respect to utilization of organization resources.
- Provides leadership and formal/informal education to staff and community through in-services, case conferences and group discussions on Hospice philosophy, criteria, medical services and pain/symptom management.
- Consistently represents Signature Hospice with integrity and professionalism to all internal and external customers.
- Actively participates as a member of the IDG and attends IDG meetings, staff meetings, department meetings, in-services, QAPI activities, Safety committee and other related activities as necessary.
- Devotes such time and attention as is necessary to fulfill his/her duties and responsibilities.

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

## EDUCATION and EXPERIENCE:

- Current MD/DO in the State of practice without any restriction or subject to any disciplinary or corrective action.
- Certification in hospice and palliative medicine is desirable.

## QUALIFICATIONS and SKILLS:

- Understands hospice and the services provided to patient and family/caregiver.
- Intimate knowledge of Medicare Hospice Benefit.
- Possess a valid driver's license and have an automobile that is insured in accordance with state and/or organization requirements.
- Demonstrates good communication and public relations skills, autonomy, organization, assertiveness, flexibility and cooperation in performing job responsibilities.
- Possess basic computer skills and knowledge of office technology- e.g. email and internet services, facsimile machines, telecommunications devices, etc.
- Can perform the Essential Job Functions/Responsibilities of this job, with or without reasonable accommodations.

# PHYSICAL REQUIREMENTS

1. In an eight (8)-hour workday:

   a. sit 2 hours

   b. stand 4 hours

   c. walk 2 hours

2. Job requires:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. Squatting | ☐ | ☒ | ☐ | ☐ |
| b. Bending | ☐ | ☒ | ☐ | ☐ |
| c. Kneeling | ☐ | ☒ | ☐ | ☐ |
| d. Reaching | ☐ | ☒ | ☐ | ☐ |
| e. Twisting | ☐ | ☒ | ☐ | ☐ |
| f. Crawling | ☒ | ☐ | ☐ | ☐ |
| g. Climbing | ☐ | ☒ | ☐ | ☐ |
| h. Walking on rough ground | ☐ | ☒ | ☐ | ☐ |
| i. Exposure to changes of temperature or humidity | ☐ | ☒ | ☐ | ☐ |
| j. Exposure to dust, fumes, or gases | ☐ | ☒ | ☐ | ☐ |
| k. Being near moving equipment | ☐ | ☒ | ☐ | ☐ |
| l. Working from heights | ☒ | ☐ | ☐ | ☐ |

3. Job requires organization personnel to lift/carry:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. 0–10 lbs | ☐ | ☒ | ☐ | ☐ |
| b. 11–24 lbs | ☐ | ☒ | ☐ | ☐ |
| c. 25–34 lbs | ☐ | ☒ | ☐ | ☐ |
| d. 35–50 lbs | ☒ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| e. 51–74 lbs | ☒ | ☐ | ☐ | ☐ |

4. Job requires organization personnel to push/pull:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. 0–10 lbs | ☐ | ☒ | ☐ | ☐ |
| b. 11–24 lbs | ☐ | ☒ | ☐ | ☐ |
| c. 25–34 lbs | ☐ | ☒ | ☐ | ☐ |
| d. 35–50 lbs | ☒ | ☐ | ☐ | ☐ |
| e. 51–74 lbs | ☒ | ☐ | ☐ | ☐ |
| f. 75–100 lbs | ☒ | ☐ | ☐ | ☐ |
| g. 100+ lbs (state weight) | ☒ | ☐ | ☐ | ☐ |

5. At work, organization personnel use feet for repetitive movements, i.e., foot controls:

**Right**: ☐ Yes ☐ No **Left**: ☐ Yes ☐ No **Both**: ☒ Yes ☐ No

6. At work, organization personnel use hands for repetitive actions such as:

| | Grasping | Grasping and Turning | Fine Manipulation | Speed Work |
|---|---|---|---|---|
| **Right**: | ☒ Yes ☐ No | ☐ Yes ☒ No | ☐ Yes ☒ No | ☒ Yes ☐ No |
| **Left**: | ☒ Yes ☐ No | ☐ Yes ☒ No | ☐ Yes ☒ No | ☒ Yes ☐ No |

7. Other aspects and demands of the job not listed above:

I have reviewed the above job description and been afforded the opportunity to have my questions answered to my satisfaction.

Employee Signature:_____ Date:_____

**EXHIBIT 15: Lease Extension Letter, Amendment, and Federal Way Lease**

OMNI PROPERTIES INC

January 28, 2021

To Whom It May Concern:

Omni Building, LLC, has approved Prime Home Health, LLC, to share space with its affiliated entity Signature Hospice Pierce, LLC. The space will be shared if Signature Hospice Pierce, LLC, is awarded a Certificate of Need in Pierce County, Washington.

Landlord: Omni Building, LLC

Mark T. Schuur, CFO

Tenant: Prime Home Health, LLC

DocuSigned by:
Mary Kofstad
73A96D5B1B014F9...

Mary Kofstad, President



33926 9th Avenue S. • Federal Way, Washington 98003-6708 • Telephone (253) 661-8095 • Fax (253) 661-8099

# AMENDMENT #2 TO LEASE

AGREEMENT ("Agreement") made as of this 28th day of January 2021, between **Omni Building, LLC,** having its principal place of business at 33926 – 9th Avenue South, Federal Way, Washington 98003 ("Landlord"), and **Prime Home Health, LLC** (formerly New Care Concepts, Inc.) a Washington limited liability company, having its place of business at 909 S. 336th Street, Suite 100, Federal Way, Washington 98003 ("Tenant").

W I T N E S S E T H :

WHEREAS, Landlord and Tenant have entered into a certain lease dated June 11, 2014, and as amended November 15, 2017.

WHEREAS, Landlord and Tenant desire to allow Tenant to sublease all or any portion of the Premises with Landlord's written approval and add a three (3) year option to renew the lease under the following terms and conditions:

## AGREEMENT

NOW, THEREFORE, in consideration of the covenants and agreements contained herein, the parties hereby mutually agree as follows:

1. **Assignment and Subletting.** Tenant shall have a right to assign or sublease all or any portion of the Premises during the term and any extension period, subject to Landlord's written approval, which shall not be unreasonably withheld or delayed.

2. **Option to Renew.** Should Tenant not be in default, the Tenant shall have a three (3) year option to renew under the same terms and conditions by providing Landlord a minimum of one hundred eighty (180) days' prior written notice. The monthly Base Rent for the renewal period shall be $7,210.00 per month.

3. **Base Rent.** The Base Rent for the existing lease term will remain:

| | |
|---|---|
| 2/1/21 – 1/31/23 | $6,700.00 per month |
| 2/1/23 – 2/29/24 | $7,000.00 per month |

4. **Full Force and Effect**. Except as expressly modified above, all terms and conditions of the Lease remain in full force and effect and are hereby ratified and confirmed.

LANDLORD: **Omni Building, LLC**

Mark T. Schuur, CFO

Date: 1-29-21

TENANT: **Prime Home Health, LLC**
a Washington limited liability company

DocuSigned by:
Mary Kofstad
73A96D5B4B014F9...

Name: Mary Kofstad, President

Date: 1/28/2021

# OFFICE BUILDING LEASE

Section 1 represents a summary of the basic terms of this Lease. In the event of any inconsistency between the terms contained in Section 1 and any specific clause of this Lease, the terms of the more specific clause shall prevail.

**1. BASIC LEASE TERMS.**

| | | |
|---|---|---|
| a. | DATE OF LEASE EXECUTION: | June 11, 2014 |
| b. | TENANT: | **New Care Concepts, Inc.,** a Washington corporation |
| | Address (Premises): | 909 S. 336th Street, Suite 202<br>Federal Way, WA 98003 |
| | Address (For Notice): | 25117 SW Parkway<br>Wilsonville, OR 97070 |
| | Phone Number: | 503-783-2470 |
| | PROJECT: | Omni Building |
| c. | LANDLORD: | Omni Building, LLC |
| | Address (For Notice): | 33926 – 9th Avenue South<br>Federal Way, WA 98003 |
| | Phone Number: | (253) 661-8095 |
| d. | TENANT'S USE OF PREMISES: | General office use |
| e. | TERM OF LEASE: | |
| | (1) Commencement Date: | September 1, 2014 |
| | (2) Expiration Date: | January 31, 2020 |
| f. | BASE MONTHLY RENT: | 9/1/14 – 1/31/15 Rent abated<br>2/1/15 – 1/31/17 $4,403.00 per month<br>2/1/17 – 1/31/19 $4,623.00 per month<br>2/1/19 – 1/31/20 $4,854.00 per month |
| g. | RENT ADJUSTMENT: | Intentionally Omitted |
| h. | TOTAL SECURITY DEPOSIT: | $4,854.00 |
| i. | PREMISES PERCENT: | 8.21% |
| j. | BASE YEAR: | 2014 |
| k. | TENANT'S FIRST ADJUSTMENT DATE: | February 1, 2017 |

l. PREMISES: That portion of the Building containing approximately 3,202 square feet of rentable area on the 2nd floor and known as Suite 202.

m. EXHIBITS: Exhibits lettered A, B, and C attached hereto and made a part hereof. In the event of any conflicts between the Exhibits and this Lease, the Exhibits shall control.

RT
Tenant's Initials

Tenant acknowledges that Tenant has read and understands all of the provisions contained in the entire Lease and all exhibits which are a part thereof and agrees that the Lease, including the Basic Lease Terms and all exhibits, reflects the entire understanding and reasonable expectations of Tenant and Landlord regarding the Premises.

## 2. PREMISES.

Landlord hereby leases to Tenant and Tenant leases from Landlord those premises described in Section 1.b., located in the Project described in Section 1.b. Landlord reserves the right to modify Tenant's Premises Percent of Project set forth in Section 1.i. (the "Premises Percent"), if the Project size is increased or decreased. By entry on the Premises, Tenant acknowledges that it has examined the Premises and accepts the Premises in its present condition.

The Premises shall include the appurtenant right to the use, in common with others, of lobbies, entrances, stairs, elevators and other public portions of the Project. All of the outside walls and windows of the Premises and any space in the Premises used for shafts, stacks, pipes, conduits, ducts, and electric or other utilities, sinks or other Project facilities, and the use thereof and access thereto through the Premises for the purposes of operation, maintenance and repairs, are reserved to Landlord.

## 3. TERM.

Fixed Term. The term of this Lease shall commence on the date set forth in Section 1.e.(1) (the "Commencement Date") and shall expire on the date set forth in Section 1.e.(2) (the "Expiration Date") unless earlier terminated as provided in this Lease. If for any reason, Landlord cannot deliver possession of the Premises to Tenant on the Commencement Date, this Lease shall not be void or voidable, nor shall Landlord be liable to Tenant for any loss or damage resulting from such delay. In that event, however, the Rent Commencement Date (as hereafter defined) shall be extended for the period of such delay, except that if in Landlord's judgment any part of the delay is caused by Tenant, rent shall not be abated for the period of delay caused by Tenant. If the Landlord determines that it cannot deliver possession of the Premises to Tenant, Landlord may by notice to Tenant terminate the lease without any liability to Landlord, in which case Tenant shall have no further liability to Landlord.

## 4. RENT.

a. Base Monthly Rent. Tenant shall pay Landlord base monthly rent in the initial amount set forth in Section 1.f in advance on the first day of each and every calendar month ("Base Monthly Rent") beginning on the date set forth in Section 1.e.(1) (the "Rent Commencement Date"). If the Rent Commencement Date is any date other than the 1st day of the calendar month, Tenant shall pay on the Rent Commencement Date a pro rata portion of the rent payable for the entire month. The fact that the Rent Commencement Date and the Commencement Date do not coincide shall not relieve Tenant of Tenant's obligation to keep and perform each and every other covenant and condition contained in this Lease. Upon execution of this lease, Tenant shall pay Landlord the first monthly installment of base rent.

b. Rent Without Offset. All rent shall be paid monthly in advance on the first day of every calendar month, at the address shown in Section 1.c., or such other place as Landlord may designate in writing from time to time. All rent shall be paid without prior demand or notice and without any deduction or offset whatsoever, in lawful currency of the United States of America. Rent due for any partial month shall be prorated at the rate of 1/30th of the total monthly rent per day.

c. Late Charge. Late payment by Tenant of any rent or other sums due under this Lease will cause Landlord to incur costs not contemplated by this Lease, the exact amount of such costs being extremely difficult and impracticable to ascertain. Such costs include, without limitation, processing and accounting charges and late charges that may be imposed on Landlord by the terms of any encumbrance on or note secured by the Premises. Therefore, if any rent is not paid within ten (10) days after it is due or other sum due from Tenant is not paid when due, Tenant shall pay to Landlord an additional sum equal to the greater of $150.00 or 10% of such overdue payment, which represents a fair and reasonable estimate of the costs that Landlord will incur by reason of any such late payment. Additionally, all delinquent rent or other sums, plus this late charge, shall bear interest at

the lesser of the then maximum lawful contract rate permitted to be charged by Landlord or if there is no maximum interest rate, 18% per annum (the "Default Rate"). If Tenant fails in two (2) months during any calendar year to make payment when due of rent or other charges required hereunder, so that a late charge is payable hereunder (whether collected or not), Landlord may require that all future payments of rent or other charges be made on or before the due date thereof by cashier's check or money order, upon demand by Landlord. Any payments returned for insufficient funds will be considered a late payment and subject to the late charge as provided in this paragraph.

d. Project Operating Costs.

(1) In order that the Rent payable during the term reflect any increase in Project Operating Costs, Tenant agrees to pay to Landlord as Rent, Tenant's Proportionate Share of all increases in costs, expenses, and obligations attributable to the Project and its operation, all as provided below.

(2) If during any calendar year during the term, the Project Operating Costs exceed the Project Operating Costs for the Base Year, Tenant shall pay to Landlord, in addition to the Base Rent and all other payments due under this Lease, an amount equal to Tenant's Proportionate Share of such excess Project Operating Costs in accordance with the provisions of this Section.

(3) The term "Project Operating Costs" shall include all those items described in the following subparagraphs (a) and (b).

(a) All taxes, assessments, water and sewer charges and other similar governmental charges levied on or attributable to the Building or Project, assessments or charges levied or assessed against the Building or Project by any redevelopment agency, and any tax measured by gross rentals received from the leasing of the Premises, Building, or Project, excluding any net income, franchise, capital stock, estate or inheritance taxes imposed by the State or Federal government or their agencies, branches, or departments, provided that if at any time during the term, any governmental entity levies, assesses, or imposes on Landlord any general or special, ad valorem or specific, excise, capital levy or other tax, assessment, levy or charge directly on the Rent received under this Lease or on the Rent received under any other Leases of space in the Building or Project, or any license fee, excise or franchise tax, assessment, levy or charge measured by or based in whole or in part upon such Rent, or any transfer, transaction, or similar tax, assessment, levy or charge based directly or indirectly upon the transaction represented by the Lease or such other leases; or any occupancy, use, per capita or other tax, assessment, levy or charge based directly or indirectly upon the use or occupancy of the Premises or other premises within the Building or Project, then any such taxes, assessments, levies and charges shall be deemed to be included in the term Project Operating Costs. If at any time during the term the assessed valuation of, or taxes on, the Project are not based on a completed Project having at least eighty-five percent (85%) of the Rentable Area occupied, then the "taxes" component of Project Operating Costs shall be adjusted by Landlord to reasonably approximate the taxes which would have been payable if the Project were completed and at least eighty-five percent (85%) occupied.

(b) Operating costs incurred by Landlord in maintaining and operating the Building and Project, including without limitation the following: costs of utilities; supplies; and insurance (including public liability, property damage, earthquake, and fire, and extended coverage insurance for the full replacement cost of the Building and Project as required by Landlord or its lenders for the Project); services of independent contractors; compensation (including employment taxes and fringe benefits) of all persons who perform duties connected with the operation, maintenance, repair or overhaul of the Building or Project, and equipment, improvements and facilities located within the Project, including without limitation engineers, janitors, painters, floor waxers, window washers, security and parking personnel and gardeners (but excluding persons performing services not uniformly available to or performed for substantially all Building or Project tenants); operation and maintenance of a room for delivery and distribution of mail to tenants of the Building or Project as required by the US Postal Service (including without limitation, an amount equal to the fair market rental value of the mailroom premises); management of the Building or Project, whether managed by Landlord or an independent contractor (including, without limitation, an amount equal to the fair market value of any on-site manager's office); rental expenses for (or a reasonable depreciation allowance on) personal property used in the maintenance, operation or repair of the Building or Project; costs, expenditures or charges (whether capitalized or not) required by any governmental or quasi-governmental authority; increases over the Base Year in the interest payable by Landlord under the promissory note (if any) evidencing the financing then in place on the Building or Project; increases over the Base Year in any ground rent for the Property payable by Landlord; amortization or capital expenses (including financing costs) required by a governmental entity for energy conservation or life safety purposes, or made by Landlord to reduce Project

Operating Costs; and any other costs or expenses incurred by Landlord under this Lease and not otherwise reimbursed by Tenants of the Project. If at any time during the Term, less than eighty-five percent (85%) of the Rentable Area of the Project is occupied, the "operating costs" component of Project Operating Costs shall be adjusted by Landlord to reasonably approximate the operating costs which would have been incurred if the Project had been at least eighty-five percent (85%) occupied.

(4) Tenant's Proportionate Share of Project Operating Costs shall be payable by Tenant to Landlord as follows:

(a) Beginning with the calendar year following the Base Year and for each calendar year thereafter ("Comparison Year"), Tenant shall pay Landlord an amount equal to any increases in Tenant's Proportionate Share of the Project Operating Costs incurred by Landlord for the Base Year. This excess is referred to as the "Excess Expenses."

(b) To provide for current payments of Excess Expenses, Tenant shall, at Landlord's request, pay as additional rent during each Comparison Year, an amount equal to any increases in Tenant's Proportionate Share of the Excess Expenses payable during such Comparison Year, as estimated by Landlord from time to time. Such payments shall be made in monthly installments, commencing on the first day of the month following the month in which Landlord notifies Tenant of the amount it is to pay hereunder and continuing until the first day of the month following the month in which Landlord gives Tenant a new notice of estimated Excess Expenses. It is the intention hereunder to estimate from time to time the amount of the Excess Expenses for each Comparison Year and any increases in Tenant's Proportionate Share thereof, and then to make an adjustment in the following year based on the actual Excess Expenses incurred for the Comparison Year.

(c) On or before June 1 of each Comparison Year after the first Comparison Year (or as soon thereafter as is practical), Landlord shall deliver to Tenant a statement setting forth any increases in Tenant's Proportionate Share of the Excess Expenses for the preceding Comparison Year. If Tenant's Proportionate Share of the actual Excess Expenses for the preceding Comparison Year exceeds the total of the estimated monthly payments made by Tenant for such year, Tenant shall pay Landlord the amount of the deficiency within ten (10) days of the receipt of the statement. If such total exceeds any increases in Tenant's Proportionate Share of the actual Excess Expenses for such Comparison Year, then Landlord shall credit against Tenant's next ensuing monthly installment(s) of additional rent an amount equal to the difference until the credit is exhausted. If a credit is due from Landlord on the Expiration Date, Landlord shall pay Tenant the amount of the credit. The obligations of Tenant and Landlord to make payments required under this section shall survive the Expiration Date.

(d) Tenant's Proportionate Share of Excess Expenses in any Comparison Year having less than 365 days shall be appropriately prorated.

(e) If any dispute arises as to the amount of any additional rent due hereunder, Tenant shall have the right after reasonable notice and at reasonable times to inspect Landlord's accounting records at Landlord's accounting office and if after such inspection Tenant still disputes the amount of additional rent owed, a certification as to the proper amount shall be made by Landlord's certified public accountant, which certification shall be final and conclusive. Tenant agrees to pay the cost of such certification unless it is determined that Landlord's original statement overstated Project Operating Costs by more than five percent (5%).

## 5. DEPOSIT.

Upon execution of this Lease, Tenant shall deposit with Landlord the amount of the security deposit set forth in Section 1.h. as security for the performance by Tenant under this Lease. If Tenant is in default, Landlord can use the security deposit to cure the default or to compensate Landlord for damages sustained by Landlord resulting from Tenant's default without prejudicing Landlord's rights hereunder. Upon demand, Tenant shall immediately pay to Landlord an amount sufficient to restore the security deposit to its original amount. If Tenant is not in default at the termination of this Lease, Landlord shall return the unused portion of the security deposit no later than forty-five (45) days after the expiration of the term of this Lease, the vacating and surrender of the Premises, and the repair and restoration of the Premises by Landlord (if Tenant fails to comply with its obligation to repair and restore hereunder). Landlord shall not be required to keep this security deposit separate from its general funds, and Tenant shall not be entitled to interest on said deposit. Landlord shall be entitled to endorse and cash immediately Tenant's prepaid deposit; however, such endorsement and cashing shall not constitute Landlord's acceptance of this Lease. If Landlord does not accept this Lease, Landlord shall return the prepaid deposit.

## 6. USE OF PREMISES, THE BUILDING AND PROJECT FACILITIES.

Tenant shall use the Premises solely for the purposes set forth in Section 1.d. and for no other purpose. Neither Landlord nor any agent of Landlord has made any representation or warranty respecting the Premises, the Building or the Project or the suitability of the Premises, the Building or the Project for the conduct of Tenant's business, nor has Landlord agreed to undertake any alteration or improvement to the Premises, the Building or the Project, except as provided in this Lease. Landlord may from time to time, in its sole discretion, make such alterations, deletions or improvements to the Building or the Project as Landlord may deem necessary or desirable, without compensation or notice to Tenant. Tenant shall promptly comply with and be responsible for its agents, employees or invitees complying with all laws, orders and regulations affecting the Premises, the Building and the Project, including the rules and regulations attached to this Lease as Exhibit B and any reasonable modifications to these rules and regulations as Landlord may adopt from time to time. Tenant shall not do or permit anything to be done in or about the Premises, the Building or Project or bring or keep anything in the Premises that will an any way increase the premium for fire or casualty insurance carried by other tenants in the Project. Tenant will not perform any act or carry on any practice that may injure the Premises, the Building or the Project; that may be a nuisance or menace to other tenants in the Building or the Project; or that shall in any way interfere with the quiet enjoyment of such other tenants. Notwithstanding the foregoing, Landlord shall not be liable to Tenant for any action of any other Tenants or their invitees, on or near the Project.

## 7. SIGNAGE.

Landlord shall install a sign inside the main entrance to Tenant's Building which shall be in Landlord's standard building form, which form may be changed from time to time by Landlord in its sole discretion, which sign shall identify Tenant's name. Tenant shall not place any additional signs in or around the Project or on any entrance to Tenant's Building or suite without prior written consent of Landlord. Any sign erected or maintained in violation hereof may be removed by Landlord at Tenant's expense.

## 8. PERSONAL PROPERTY TAXES.

Tenant shall pay before delinquency all taxes, assessments, license fees and public charges imposed upon its business operations as well as upon all trade fixtures, leasehold improvements, merchandise and other personal property in or about the Premises.

## 9. PARKING.

Tenant is granted a non-exclusive license to use the designated parking areas in the Project for the use of motor vehicles during the term of this Lease. Landlord reserves the right at any time to grant similar non-exclusive use to other tenants, to promulgate rules and regulations relating to the use of such parking areas, including reasonable restrictions on parking by tenants, employees and invitees, to designate specific spaces for the use of any tenant, to make changes in the parking layout from time to time, and to limit Tenant's use of the parking areas to a figure based on the relationship between the square footage of the Premises and the Building. Overnight parking is prohibited, and any vehicle of Tenant, its employees, guests or invitees violating this or any other vehicle regulation adopted by Landlord is subject to removal without notice at Tenant's expense.

## 10. SERVICES AND UTILITIES.

a. Provided that Tenant is not in default hereunder, Landlord agrees to furnish to the Premises between the hours of 7:00 a.m. through 7:00 p.m., Monday through Friday electricity for normal lighting and fractional horsepower office machines, heat and air conditioning, water, sewer and garbage services required in Landlord's judgment for the comfortable use and occupation of the Premises, and janitorial service (not more frequently than five (5) times per week) which shall be limited to light vacuuming, trash disposal, replacement of ceiling light lamps and washroom paper products. Landlord shall not be liable for, and Tenant shall not be entitled to, any reduction of Rent by reason of Landlord's failure to furnish any of the foregoing when such failure is caused by accident, breakage, repairs, strikes, lockouts or other labor disturbances or labor disputes of any character or by any other cause, similar or dissimilar, beyond the reasonable control of and not resulting from the negligence of Landlord. Landlord shall not be liable for a loss or injury to

property, however occurring, through or in connection with or incidental to failure to furnish any of the foregoing. Wherever heat generating machines or equipment are used in the Premises which affect the temperature otherwise maintained by the air conditioning system, Landlord reserves the right to install supplementary air conditioning units in the Premises, and the cost thereof, including the cost of installation and the cost of operation and maintenance thereof, shall be paid by Tenant to Landlord upon demand by Landlord.

b. Tenant shall not, without written consent of Landlord, use any apparatus or device in the Premises, including, but without limitation thereto, electronic data processing machines, punch card machines, and machines using in excess of 120 volts, which will in any way increase the amount of electricity usually furnished or supplied for the use of the Premises as general office space; nor connect with electric current except through existing electrical outlets in the Premises, any apparatus or device, for the purpose of using electric current. If Tenant shall require water or electric current in excess of that usually furnished or supplied for the use of the Premises as general office space, Tenant shall first procure the written consent of Landlord, which Landlord may refuse, to the use thereof, and Landlord may cause a water meter or electrical current meter to be installed in the Premises, so as to measure the amount of water and electric current consumed for any such use. The cost of any such meters and of installation, maintenance and repair thereof shall be paid for by the Tenant, and Tenant agrees to pay Landlord promptly upon demand therefore by Landlord for all such water and electric current consumed as shown by said meters, at the rates charged for such services by the local public utility furnishing the same, plus any additional expense incurred in keeping account of the water and electric current so consumed. If a separate meter is not installed, such excess cost for such water and electric current will be established by an estimate made by Landlord.

## 11. MAINTENANCE.

Except for damage caused by any negligent or intentional act or omission of Tenant or Tenant's agents, employees or invitees, Landlord shall maintain in good condition the structural parts of the Building, which shall include only the foundations, bearing and exterior walls (excluding glass), subflooring and roof (excluding skylights), those portions of the electrical, plumbing and sewage systems lying outside of the Premises, gutters and down spouts on the Building and the heating, ventilating and air conditioning system servicing the Premises and the Common Areas of the Project. In no event shall Tenant be entitled to undertake any such maintenance or repairs, whether at the expense of Tenant or Landlord, and Tenant hereby waives the benefits of any law now or hereafter in effect which would otherwise provide Tenant with such right. Landlord shall have no obligation to perform any maintenance under this Section unless Landlord determines in its sole discretion that such maintenance is necessary and until a reasonable time after receipt of written notice of the need for such maintenance. The Lease and Tenant's obligation hereunder shall in no way be affected, impaired or excused because Landlord is unable to fulfill any of its obligations under this Lease if Landlord is prevented or delayed from so doing by reason of fire, earthquake, inclement weather or other acts of God, acts of the public enemy, riot, insurrection, governmental regulation of the sales of materials or supplies or the transportation thereof, strikes or boycotts, shortages of materials or labor, or any other cause beyond the control of and not the result of the negligence of Landlord.

Except as provided above, Tenant, at its sole cost, shall maintain and repair every part of the interior of the Premises including, without limitation, carpets (including carpet replacement and cleaning), drapes, all walls, floors, ceilings, interior and exterior doors and windows and their appurtenant sills and frames, together with all fixtures, security devices, appliances, and equipment, and will make all repairs and replacements thereto at its own expense. Tenant, at its sole cost, shall also be responsible for all repairs and alterations in and to the Premises, Building and Project and the facilities and systems thereof, the need for which arises out of (i) Tenant's use or occupancy of the Premises, (ii) the installation, removal, use or operation of Tenant's personal property and fixtures in the Premises, or (iii) the moving of Tenant's personal property and fixtures into or out of the Building.

Upon termination of this Lease, Tenant shall surrender the Premises to Landlord in the same condition as existed at the commencement of the term, except for reasonable wear and tear or damage caused by fire or other casualty for which Landlord has received all funds necessary for restoration of the Premises from insurance proceeds.

## 12. ALTERATIONS.

Tenant shall not make any alterations to the Premises, the Building or to the Project (including any changes to the existing landscaping), without Landlord's prior written consent, other than alterations costing less than $1,000.00, so long as such alterations shall not affect the appearance or function of the Premises. Any alterations shall remain on and be surrendered with the Premises upon termination of this Lease, except that Landlord may, on or before thirty (30) days after termination of this Lease, require Tenant to remove any alterations made by Tenant. If Landlord so elects, Tenant at its own cost shall restore the Premises to the condition designated by Landlord in its election, before the last day of the term or within thirty (30) days after notice of its election is given, whichever is later.

A proposal for any alterations in or about the Premises that Tenant shall desire to make and which requires the prior consent of Landlord shall be presented to Landlord in written form accompanied by a complete set of detailed plans and specifications for such proposed alteration. Should Landlord consent in writing to Tenant's alteration of the Premises, Tenant shall contract with a contractor pre-approved by Landlord for the construction of such alterations, shall secure all appropriate governmental approvals and permits, and shall complete such alterations with due diligence in compliance with plans and specifications approved by Landlord. All such construction shall be performed in a manner which will not interfere with the quiet enjoyment of other tenants of the Project. Tenant shall pay all costs for such construction and keep the Premises, the Building and Project free and clear of all mechanics' items which may result from construction by Tenant. Prior to commencement of any construction, Tenant shall post and file on behalf of Landlord a notice of non-responsibility or other similar notice permitted under applicable law and shall deliver to Landlord a lien and completion bond in the amount of 1½ times the cost of construction. As used in this Section 12, "cost" shall include the full commercial value of labor and materials for any such alterations.

## 13. RELEASE AND INDEMNITY.

As material consideration to Landlord, Tenant agrees that Landlord shall not be liable to Tenant for any damages to Tenant or Tenant's property from any cause, other than the gross negligence or willful misconduct of Landlord which shall include Landlord's failure to make repairs required by Section 11, and Tenant waives all claims against Landlord for damage to person or property arising for any reason, except for damage resulting directly from Landlord's gross negligence or willful misconduct. Tenant shall indemnify, hold harmless, and at Landlord's option, defend Landlord from any and all legal and equitable claims, demands, causes of action, liabilities, obligations, costs and expenses (including reasonable attorneys' fees, court costs and litigation expenses) of any kind arising out of the injury, damage or other loss to any person or property occurring in, on or about the Premises or arising out of the use of the Premises, the Building or Project by Tenant, its employees or invitees or Tenant's breach of this Lease. Tenant's obligation under this Section 13 shall not be limited to the amounts of coverage of insurance maintained or required to be maintained by Tenant under this Lease. It is the intention of the parties that this indemnity does not require payment as a condition precedent to recovery by Landlord against Tenant under this indemnity and that Landlord shall be indemnified by Tenant to the full extent permitted by law.

## 14. INSURANCE.

a. Tenant's Liability Insurance. Tenant at its cost shall maintain broad form comprehensive general liability insurance, including personal injury, property damage, completed operations and fire legal liability coverage with a single combined liability limit of not less than one million and no/100 dollars ($1,000,000.00) for bodily, injury, property damage and personal injury. Such coverage shall insure against all liability of Tenant and its authorized representatives arising out of or in connection with Tenant's use or occupancy of the Premises. The broad form comprehensive liability insurance shall insure performance by Tenant of the indemnity provisions of Section 13, and the policy shall name Landlord as additional insured.

b. Tenant's Workers' Compensation Insurance. Tenant shall maintain workers' compensation and employers' liability insurance affording statutory workers' compensation benefits for the state in which the Premises are located and employers' liability coverage in an amount not less than one hundred thousand and no/100 dollars ($100,000.00).

c. Tenant's Fire Insurance. On all its personal property, at its cost, Tenant shall maintain a policy of standard fire and extended coverage insurance with vandalism and malicious mischief endorsements and "all risk" coverage, including earthquake and flood, on all Tenant's improvements and alterations in or about the Premises, for their full replacement value. The proceeds from any such policy shall be used by Tenant for the replacement of personal property and the restoration of Tenant's improvements or alterations.

d. Insurance Requirements. All insurance required to be provided by Tenant under this Lease:

(1) shall be issued by insurance companies which are authorized to do business in the State of Washington and which have a financial rating as assigned by Best's Insurance Reports which is acceptable to Landlord;

(2) shall be issued as a primary policy and shall expressly provide that any policies carried by Landlord shall be excess and noncontributory of such primary insurance;

(3) shall, with the exception of the workers' compensation and employers' liability policy, name Landlord as additional insured and shall expressly provide that the interest of Landlord shall be determined by any breach of Tenant of any policy provision; and

(4) shall expressly require the insurance company to provide at least thirty (30) days prior written notice to Landlord and if requested, to Landlord's lender, before cancellation or change in coverage, scope or amount of any policy. Tenant shall deliver a certificate of insurance to Landlord on or prior to the Commencement Date and thereafter at least thirty (30) days prior to policy expiration.

f. Substitute Performance. If the Tenant fails to comply with this Section 14, Landlord may obtain such insurance, and Tenant shall pay to Landlord upon demand as additional rent the premium costs thereon.

g. Landlord's Insurance. Landlord may, but shall not be obligated to, insure the Project and maintain public liability insurance for the protection of Landlord. If Landlord elects to insure the Project and maintain such insurance, the amounts thereof and the deductibles in connection therewith shall be determined by Landlord in its sole discretion. The insurance referred to in this subparagraph "g" is not to be construed as any of the insurance required under subparagraphs "a" through "f" above.

## 15. DESTRUCTION.

a. If the Premises or the portion of the Building necessary for Tenant's occupancy is damaged by fire, earthquake, act of God, the elements or other casualty, Landlord shall, subject to the provisions of this Section 15, repair the damage, if such repairs can, in Landlord's sole opinion, be completed within ninety (90) days. If Landlord determines that repairs can be completed within ninety (90) days, this Lease shall remain in full force and effect, except that if such damage is not the result of negligence or willful misconduct of Tenant, or Tenant's agents, employees, contractors, licensees or invitees, the Base Monthly Rent shall be abated to the extent Tenant's use of the Premises is impaired, commencing with the date of damage and continuing until the completion of the repairs required of Landlord by Section 15.d.

b. If in Landlord's sole opinion, such repairs to the Premises or portion of the Building necessary for Tenant's occupancy cannot be completed within ninety (90) days, Landlord may elect, upon notice to Tenant given within thirty (30) days after the date of such fire or other casualty, to repair such damage, in which event this Lease shall continue in full force and effect, but the Base Monthly Rent shall be partially abated as provided in Section 15.a. If Landlord does not so elect to make such repairs, this Lease shall terminate as of the date of such fire or other casualty.

c. If any other portion of the Building or Project is destroyed or damaged to the extent that in Landlord's opinion repair thereof cannot be completed within ninety (90) days, Landlord may elect upon notice to Tenant given within thirty (30) days after the date of such fire or other casualty, to repair such damage, in which event this Lease shall continue in full force and effect, but the Base Monthly Rent shall be partially abated as provided in Section 15.a. If Landlord does not elect to

make such repairs, this Lease shall terminate as of the date of such fire or other casualty.

d. If the Premises are to be repaired under this Section, Landlord shall use its best efforts to commence to restore the Building and the Premises (but not Tenant's fixtures, equipment, alterations or tenant improvements which shall be Tenant's responsibility) to the condition existing immediately prior to the damage in compliance with then existing laws. Landlord shall not be liable for any loss of business, inconvenience or annoyance arising from any repair or restoration of any portion of the Premises, Building or Project as a result of any damage from fire or other casualty nor shall Landlord be responsible for any delays in completing such repair or restoration occasioned by acts of God, adjustment of insurance, labor trouble, governmental controls (including, but not limited to, zoning and building codes or the application of any growth management legislation or administrative rules), unavailability of material, or any other cause beyond Landlord's reasonable control.

e. This Lease shall be considered an express agreement governing any case of damage to or destruction of the Premises, Building or Project by fire or other casualty, and any present or future law which purports to govern the rights of Landlord and Tenant in such circumstance in the absence of express agreement, shall have no application.

## 16. CONDEMNATION.

a. Definitions. The following definitions shall apply: (1) "Condemnation" means (a) the exercise of any governmental power of eminent domain, whether by legal proceedings or otherwise by the condemnor and (b) the voluntary sale or transfer by Landlord to any condemnor either under threat of condemnation or while legal proceedings for condemnation are pending; (2) "Date of Taking" means the date the condemnor has the right to possession of the property being condemned; (3) "Award" means all compensation, sums or anything of value awarded, paid or received on a total or partial condemnation; and (4) "Condemnor" means any public or quasi-public authority, or private corporation or individual, having a power of condemnation.

b. Obligations to be Governed by Lease. If during the term of this Lease, any Condemnation of all or any part of the Premises, the Building or the Project occurs, the rights and obligations of the parties shall be governed by this Lease.

c. Total or Partial Taking. If the Project or the Building or the Premises are totally taken by Condemnation, this Lease shall terminate on the date of taking. If any portion of the Premises or the Building is taken by Condemnation, the Lease shall remain in effect, except that Tenant can elect to terminate this Lease if the remaining portion of the Premises is reasonably rendered unsuitable for Tenant's continued use of the Premises by giving notice to Landlord within thirty (30) days after the nature and extent of the taking have been finally determined, setting forth the date of termination, which shall not be earlier than thirty (30) days nor later than ninety (90) days after delivery of the notice. Tenant shall have no claim against Landlord for the value of any unexpired term of the Lease. If any portion of the Premises is taken by Condemnation and this Lease remains in effect, on the date of taking the Base Monthly Rent shall be reduced in the proportion that the total number of square feet in the Premises taken bears to the total number of square feet in the Premises immediately before the date of taking. Any partial taking of the Project that does not affect the Premises shall not result in a rent reduction or abatement. Landlord shall not be liable for any loss of business, inconvenience or annoyance arising from any repair or restoration of any portion of the Premises, Building or the Project as a result of any damage from fire or other casualty. Any award for any total or partial taking shall be the property of Landlord; nothing, however, shall preclude Tenant from obtaining any award for loss of or damage to Tenant's trade fixtures or removal of personal property or for damages for cessation or interruption of Tenant's business or for relocation costs.

## 17. ASSIGNMENT OR SUBLEASE.

a. Prohibition. Tenant shall not assign or encumber its interest in this Lease or the Premises or sublease all or any part of the Premises or allow any other person or entity (except Tenant's authorized representatives, employees, invitees or guests) to occupy or use all or any part of the Premises either voluntarily, involuntarily or by operation of law without first obtaining Landlord's written consent. If Tenant is a partnership, a withdrawal or change of any general partner, or the dissolution of the partnership, shall be deemed an assignment. If Tenant consists of more than one person, an assignment from one person to the other shall be deemed an assignment. If Tenant is a

entity, any dissolution or any transfer of twenty-five percent (25%) or more of the ownership interests of Tenant, except for stock which is traded through an exchange or over the counter or in connection with the conversion of Tenant from a corporation to a limited liability company, shall be deemed an assignment. Any assignment, encumbrance or sublease in violation hereof shall be voidable and, at Landlord's election, shall constitute a default. Acceptance of rent by Landlord from anyone other than Tenant shall not be construed as a waiver by Landlord of the actions prohibited by this paragraph, nor as a release of Tenant from any obligation or liability under this Lease, but the same shall be taken to be a payment on account by Tenant.

b. Payments to Landlord. If Landlord consents to a proposed assignment or sublease, then Landlord will have the right to require Tenant to pay to Landlord a sum equal to (a) any rent or other consideration paid to Tenant by any proposed transferee that (after deducting the costs of Tenant, if any, in effecting the assignment or sublease, including reasonable alteration costs, commissions and legal fees) is in excess of the rent allocable to the transferred space then being paid by Tenant to Landlord pursuant to this Lease; (b) any other profit or gain (after deducting any necessary expenses incurred) realized by Tenant from any such sublease or assignment; (c) Landlord's reasonable attorneys' fees and costs incurred in connection with negotiation, review and processing of the transfer; and (d) a lease transfer fee in the amount of $1,000. All such sums payable will be payable to Landlord at the time the next payment of monthly rent is due.

c. Excess Rent. All rent or other consideration received by Tenant from its subtenants in excess of the rent payable by Tenant to Landlord under this Lease for the sublet space shall be paid to Landlord. Any sums to be paid by an assignee to Tenant in consideration of the assignment of this Lease, whether paid in a lump sum or periodically, shall belong to and be paid to Landlord.

d. No Waiver. No consent by Landlord to any assignment or subletting by Tenant shall relieve Tenant or any guarantor of Tenant of any obligation to be performed by Tenant under this Lease, whether accruing before or after such assignment or subletting.

e. Assumption of Liability. Each assignee, other than Landlord, shall assume and covenant to perform all obligations of Tenant under this Lease. Tenant shall be and remain liable jointly and severally with assignee for performance of Tenant's obligations. No assignment shall be binding on Landlord unless such assignee or Tenant shall deliver to Landlord a counterpart of such assignment fully signed by all parties to the agreement and an instrument in recordable form which contains a covenant of assumption of the assignee satisfactory in substance and form to Landlord. No assignment or sublease shall relieve Tenant of its obligation hereunder.

f. Involuntary Assignments. No interest of Tenant in this Lease shall be assignable by involuntary assignment through operation of law (including without limitation the transfer of this Lease by will or intestacy). Each of the following acts shall be considered an involuntary assignment by Tenant, and Guarantor or any Partner, if Tenant is a partnership ("Tenant, et al"):

(1) Bankruptcy and Insolvency. "Tenant, et al" becomes insolvent as defined in the Federal Bankruptcy Code, admits in writing its insolvency or its present or prospective inability to pay its debts as they become due, is unable to or does not pay all or any material portion (in number or dollar amount) of its debts as they become due, permits or suffers a judgment against "Tenant, et al" which affects "Tenant's, et al" ability to conduct its business in the ordinary course, (unless enforcement thereof is stayed pending appeal), makes or proposes an assignment for the benefit of creditors, convenes or proposes to convene a meeting of its creditors, or any class thereof, for purposes of effecting a moratorium upon or extension or composition of its debts, proposes any such moratorium, extension, or composition, or commences or proposes to commence any bankruptcy, reorganization, or insolvency proceeding, or other proceeding under any provision or chapter of the Federal Bankruptcy Code or any other federal, state, or other law for the relief of debtors.

(2) Dismissal or Stay of Proceedings. "Tenant, et al" fails to obtain the dismissal, within thirty (30) days after the commencement thereof, of any bankruptcy, reorganization, or insolvency proceeding, or other proceeding under any law for the relief of debtors, instituted against "Tenant, et al" by one or more third parties or fails actively to oppose any such proceeding, or, in any such proceeding, defaults or files an answer admitting the material allegations upon which the proceeding was based or alleges its willingness to have an order for relief entered or its desire to seek liquidation, reorganization, or adjustment of any of its debts.

(3) Receivers. Any receiver, trustee, or custodian is appointed to take possession of all or any assets of "Tenant, et al" or any committee of "Tenant's, et al, creditors, or any class thereof, is formed for the purpose of monitoring or investigating the financial affairs of "Tenant, et al" or enforcing such creditors' rights.

**18. DEFAULT.**

If Tenant (i) shall fail to pay any rent when due, (ii) shall fail to pay any other sum of money due hereunder when due (although no legal or formal demand has been made therefore) and shall fail to pay the same within ten (10) days of when due, (iii) shall fail to occupy the Premises at all times during the term of this Lease, except the periods, if any, during which tenant improvements are initially being constructed or the Premises are unusable by Tenant as provided in Sections 15 and 16 hereof, notwithstanding Tenant's payment of rent, or (iv) shall violate or fail to perform any other provision and shall fail to correct or perform the same within thirty (30) days after written notice thereof from Landlord, then this Lease shall be in default and at any time thereafter Landlord may at its option:

a. terminate this Lease and Tenant's right to possession of the Premises; or

b. without terminating this Lease, re-enter, take possession of the Premises and remove all persons and property therefrom (such property as may be removed may be stored in a public warehouse or elsewhere at the cost of and for the account of Tenant), all without notice or legal process and without being deemed guilty of trespass, or liable for any loss or damage occasioned thereby. If Tenant shall, after default, voluntarily give up possession to Landlord, deliver to Landlord the keys to the Premises, or both, such actions shall be deemed to be in compliance with Landlord's rights and the acceptance thereof by Landlord shall not be deemed to constitute a surrender of the Premises. Should Landlord elect to re-enter, as herein provided, or should it take possession pursuant to legal proceedings or pursuant to any notice provided by law, it may either terminate this Lease or it may from time to time without terminating this Lease, make such alterations and repairs as may be necessary in order to relet the Premises, and relet said Premises or any part thereof for such rental or rentals and upon such other terms and conditions as Landlord in its sole discretion may deem advisable; upon each such reletting all rentals received by Landlord from such reletting shall be applied; first, to the payment of any indebtedness other than rent due hereunder from Tenant to Landlord; second, to the payment of any costs and expenses of such reletting, including brokerage fees and attorney's fees, and costs of such alterations and repairs; third, to the payment of rent due and unpaid hereunder and the residue, if any, shall be held by Landlord and applied in payment of future rent or damage as the same may become due and payable hereunder. If such rentals received from such reletting during any month be less than that to be paid during that month by Tenant hereunder, Tenant shall pay such deficiency to Landlord, the same calculated and paid monthly. No such re-entry or taking possession of said Premises by Landlord shall be construed as an election on its part to terminate this Lease, unless a written notice of such intention be given to Tenant or unless the termination thereof be decreed by a court of competent jurisdiction. Notwithstanding any such reletting without termination, Landlord may at any time thereafter elect to terminate this Lease for such previous breach. Should Landlord at any time terminate this Lease for any breach, in addition to any other remedies it may have, it may recover from Tenant all damages it may incur by reason of such breach, including the following:

(1) the cost of recovering the Premises;
(2) reasonable attorney's fees;
(3) the worth at the time of award of earned, but unpaid rent;
(4) the worth at the time of award of the amount by which unpaid rent which would have been earned after termination until the time of award exceeds the amount of such rental loss that Tenant proves could have been reasonably avoided;
(5) the worth at the time of award of the amount by which unpaid rent for the balance of the term of the Lease after the time of the award exceeds the amount of such rental loss that Tenant proves could have been reasonably avoided; and
(6) any other amounts necessary or provided for under applicable law to compensate Landlord for all the detriment proximately caused by

Tenant's failure to perform its obligations under the Lease or which in the ordinary course of things would be likely to result therefrom.

In case suit shall be brought for recovery of possession of the Premises, for the recovery of rent or other amount due under the provisions of this Lease or because of the breach of any other covenant herein contained on the part of Tenant to be kept or performed and a breach shall be established, Tenant shall pay to Landlord all expenses incurred therefore, including reasonable attorney's fees.

Landlord shall not be obligated to notify Tenant of the due date of rent nor demand payment thereof on its due date, the same being expressly waived by Tenant. The acceptance of any sums of money from Tenant after the expiration of any ten (10) day or thirty (30) day notice as above provided shall be taken to be payment on account by Tenant and shall not constitute a waiver by Landlord of any rights, nor shall it reinstate the Lease or cure a default on the part of Tenant. All rights and remedies of Landlord under this Lease shall be cumulative and shall not be exclusive of any other rights and remedies provided to Landlord under applicable law.

## 19. ENTRY ON PREMISES.

a. Entry. Landlord and its agents shall have the right to enter the Premises at all reasonable times for the purpose of examining or inspecting the same, to supply any service to be provided by Landlord or Tenant hereunder, to show the same to prospective Purchasers, Lenders, or Tenants of the Project, and to make such alterations, repairs, improvements or additions to the Premises or to the Building as Landlord may deem necessary or desirable. If Tenant shall not be personally present to open and permit an entry into the Premises at any time when such entry by Landlord is necessary or permitted hereunder, Landlord may enter by means of a master key without liability to Tenant, except for any failure to exercise due care for Tenant's property, and without affecting this Lease. Landlord, during the entire term of this Lease, shall have the right, upon forty-five (45) days' prior written notice to Tenant, to change the name, number or designation of all or any portion of the Project without liability to Tenant. Landlord may at any time place on or about the Premises any ordinary "for lease" signs; Landlord may at any time place on or about the Premises any ordinary "for sale" signs.

b. Keys. Landlord shall at all times have and retain a key with which to unlock all the doors in, upon and about the Premises, excluding Tenant's vaults and safes. Tenant shall not alter any lock or install a new or additional lock or bolt on any door of the Premises without prior written consent of Landlord. If Landlord shall give its consent, Tenant shall in each case furnish Landlord with a key for any such lock.

## 20. SUBORDINATION.

Without the necessity of any additional document being executed by Tenant and at the election of Landlord or any mortgagee or any beneficiary of a deed of trust on the Project or any ground lessor of the Project, this Lease shall be subject and subordinate at all times to all ground leases or underlying leases which may now exist or hereafter be executed in any amount encumbering the Project, ground leases or underlying leases, or Landlord's interest or estate in any of them. If any ground lease or underlying lease terminates for any reason or any mortgage or deed of trust is foreclosed or a conveyance in lieu of foreclosure is made for any reason, notwithstanding this subordination, Tenant shall attorn to and become the Tenant of the successor in interest at the option of such successor in interest. Tenant shall execute and deliver any additional documents in the form requested by Landlord, evidencing the priority or subordination of this Lease with respect to any such ground lease or underlying leases or the lien of any such mortgage or deed of trust.

## 21. ESTOPPEL CERTIFICATES.

Within ten (10) days after notice from Landlord, Tenant shall execute and deliver to Landlord a certificate stating such matters reflecting the status of this Lease or the Premises as Landlord, Landlord's lender, purchaser, or ground lessor may reasonably request. If Tenant shall fail to deliver the certificate within ten (10) days, then any representations of Landlord respecting the matters covered by the certificate shall be conclusively presumed to be accurate. However, Tenant's default shall not be cured thereby, and Tenant shall continue to be obligated to deliver the certificate. Tenant shall pay to Landlord a fee of ten dollars ($10.00) per day for every day after the ten (10) day period

provided above that Tenant fails to deliver the certificate required under this Section 21.

## 22. NOTICE.

Any notice, demand, request, consent, approval or communication desired by either party or required to be given, shall be in writing and served either personally or sent by a nationally recognized overnight courier, addressed as set forth in Section 1. Either party may change its address by written notification to the other party. Notice shall be deemed to be given upon confirmed delivery.

## 23. WAIVER.

No delay or omission in the exercise of any right or remedy or acceptance of any payment or portion thereof due hereunder by Landlord shall impair such right or remedy or be construed as a waiver. No act or conduct of Landlord, including, without limitation, acceptance of the keys to the Premises, shall constitute an acceptance of the surrender of the Premises by Tenant before the expiration of the term. Only written notice from Landlord to Tenant of such acceptance shall constitute acceptance of the surrender of the Premises and accomplish termination of this Lease. Landlord's consent to any act by Tenant shall not be deemed to waive or render unnecessary Landlord's consent to any subsequent act by Tenant. Any waiver by Landlord of any default must be in writing and shall not be a waiver of any other default concerning the same or any other provision of this Lease.

## 24. SURRENDER OF PREMISES; HOLDING OVER.

Upon expiration of the term, Tenant shall surrender to Landlord the Premises and all Tenant improvements and alterations in good condition, except for ordinary wear and tear and alterations Tenant has the right or is obligated to remove under Section 12. Tenant at its expense shall remove all personal property and, unless Landlord otherwise elects, all wall covering, paneling and other decorative improvements or fixtures and shall perform all restoration to the condition prior to occupancy made necessary by the removal of any alterations or Tenant's personal property before the expiration of the term. Landlord can elect to retain or dispose of in any manner Tenant's personal property not removed from the Premises by Tenant prior to the expiration of the term. Tenant waives all claims against Landlord for any damage to Tenant resulting from Landlord's retention or disposition of Tenant's personal property. Tenant shall be liable to Landlord for Landlord's costs for storage, removal or disposal of Tenant's personal property.

If Tenant, with Landlord's consent, remains in possession of the Premises after expiration of this Lease, such possession by Tenant shall be deemed to be a month-to-month tenancy on all provisions of this Lease, except those pertaining to term and rent. Tenant shall pay an amount equal to 125% of Base Monthly Rent for the last full, calendar month during the regular term. So long as Tenant is in possession of the Premises under such month-to-month tenancy, Landlord shall have the rights provided it at law or equity including, without limitation, the right upon thirty (30) days notice to (1) terminate Tenant's right to possession of the Premises; (2) make adjustments in the amount payable as Base Monthly Rent; or (3) make such other changes to the terms and provisions of this Lease as Landlord in its sole discretion shall determine.

## 25. DEFAULT OF LANDLORD; LIMITATION OF LIABILITY.

In the event of any default by Landlord hereunder, Tenant agrees to give notice of such default, pursuant to Section 22, to Landlord at Landlord's Notice Address as stated in 1(c) and to offer Landlord a reasonable opportunity but in no event less than thirty (30) days to cure the default. Such Notice shall be given as herein provided no later than thirty (30) days after the occurrence of the default.

In the event of any actual or alleged failure, breach or default hereunder by Landlord, Tenant's sole and exclusive remedy shall be against the Project and Landlord's interest therein, and no principal of Landlord shall be sued, be subject to service of process, or have a judgment obtained against such principal in connection with any alleged breach or default, and no writ of execution shall be levied against the assets of any principal of Landlord. The covenants and agreements are enforceable by Landlord and also by any principal of Landlord.

## 26. LANDLORD'S RULES.

Tenant shall faithfully observe and comply with the Rules that Landlord shall from time to time promulgate. Landlord reserves the right from time to time to make all reasonable modifications to such Rules. The additions and modifications to those Rules shall be binding upon Tenant upon delivery of a copy of them to Tenant. Landlord shall not be responsible to Tenant for the non-compliance with any such Rules by other tenants or occupants. The parties acknowledge that the Rules attached hereto as Exhibit B are presently the Rules which are in effect.

## 27. PAYMENT UNDER PROTEST.

No payment by Tenant or receipt by Landlord of a lesser amount than stipulated herein for Rent, additional Rent or any other charge hereunder shall be deemed other than payment on account of the earliest stipulated Rent, additional Rent or other charge then due, nor shall any endorsement or statement on a check or letter accompanying any check or payment be deemed an accord and satisfaction. Landlord may accept such check or payment without prejudice to Landlord's rights to recover the balance of such Rent, additional Rent or other charges or pursue any other remedy in this Lease, at law or in equity.

## 28. MISCELLANEOUS PROVISIONS.

a. Time of Essence. Time is of the essence of each provision of this Lease.

b. Successor. This Lease shall be binding on and inure to the benefit of the parties and their successors, except as provided in Section 17.

c. Landlord's Consent. Any consent required by Landlord under this Lease must be granted in writing and may be withheld by Landlord in its sole and absolute discretion, except where otherwise expressly stated in this Lease, and any delay in consenting will not be a breach of this Lease.

d. Other Charges.

(1) If Landlord becomes a party to any litigation concerning this Lease, the Premises, Building or the Project, by reason of any act or omission of any act of Tenant or Tenant's authorized agents, employees or invitees, Tenant shall be liable to Landlord for reasonable attorneys' fees, court costs and litigation expenses incurred by Landlord in the litigation, whether or not such litigation leads to actual court action.

(2) If either party commences an action against the other party arising out of this Lease, the prevailing party shall be entitled to recover from the other party reasonable attorneys' fees, court costs and litigation expenses, as determined by the court, at trial, on any appeal therefrom, and in any bankruptcy proceeding, including adversary proceedings or hearings on motions.

(3) If Landlord employs a collection agency or attorney to recover delinquent amounts, Tenant shall pay all collection agency or attorney's fees charged to Landlord in addition to rent, late charges, interest and other sums payable under this Lease.

e. Additional Rent. All monetary sums due from Tenant to Landlord under this Lease shall be deemed to be rent.

f. Financial Statements. Upon submission of this Lease to Landlord and any time thereafter within thirty (30) days after delivery of a request from Landlord, Tenant shall furnish to Landlord copies of Tenant's most recent certified or audited financial statements, including, without limitation, statements of profits and losses. Tenant hereby represents and warrants that financial statements submitted are true, accurate and up-to-date representations of its financial condition including, without limitation, all of its assets, liabilities, income and sources of income as of the date thereof. If Landlord desires to finance, refinance or sell the Project or any part thereof, Tenant hereby agrees to deliver to any lender or prospective purchaser designated by Landlord such financial statements of Tenant as may be reasonably required by such lender or prospective purchaser.

g. Landlord's Successors. In the event of a conveyance or ground lease of the Project or the

Premises, the same shall operate to release Landlord from any liability under this Lease, including the obligation to return the Security Deposit, and in such event Landlord's successor in interest or ground lessee shall be solely responsible for all obligations of Landlord under this Lease.

h. Interpretation. This Lease shall be construed and interpreted in accordance with the laws of the State of Washington. This Lease (including the exhibits and any addendum attached hereto) constitutes the entire agreement between the parties respecting the Premises and the Project, except for such guarantees or modifications as may be executed in writing by the parties from time to time. When required by the context of this Lease, the singular shall include the plural, and the masculine shall include the feminine and/or neuter. "Party" shall mean Landlord or Tenant. If more than one person or entity constitutes Landlord or Tenant, the obligations imposed upon that party shall be joint and several. The enforceability, invalidity or illegality of any provision shall not render the other provisions unenforceable, invalid or illegal. All provisions, whether conditions or covenants on the part of Tenant, shall be deemed to be both conditions and covenants.

i. Security Measures. Tenant acknowledges, understands and agrees that Landlord shall have no obligation or responsibility to provide guard service or other security measures for the benefit of the Premises or the Project. Tenant assumes sole responsibility for the protection of Tenant, its agents and invitees and the property of Tenant and of Tenant's agents and invitees from acts of third parties. Landlord may, at its sole option, however, provide security protection for the Premises or Project.

j. Landlord Substitute Performance. If Tenant defaults in the performance of any obligation under this Lease, Landlord in its sole discretion may without notice perform such obligation, in which event Tenant shall pay Landlord as additional rent all sums paid by Landlord in connection with such substitute performance within three (3) days following Landlord's written notice for such payment. Any delinquent sum shall bear interest at the Default Rate.

k. Accessibility Laws. "Accessibility Law" means any local, State, or federal law, regulation, ordinance, resolution, order, or directive relating to access, use or enjoyment of the Premises by, or employment thereupon, of handicapped persons, or to the removal of any tangible or intangible barrier or impediment to access, use, or enjoyment of the Premises by handicapped persons, including, but not limited to the Americans with Disabilities Act. Notwithstanding anything in this Lease to the contrary, Tenant shall make no alteration that violates any provision of any Accessibility Law. Tenant shall not adopt or otherwise allow to exist any policy or practice related to Tenant's use or occupancy of the Premises or the conduct of its activities thereon that violates any Accessibility Law. Tenant shall keep the Premises, its activities conducted thereon, and Tenant's trade fixtures and personal property located thereon in compliance with all Accessibility Laws and make any alterations, improvements, or additions to the Premises as may be required to achieve such compliance. Tenant shall also adopt any economically feasible policy or practice relating to the conduct of Tenant's business upon the Premises that would cure any existing violation of any Accessibility Law relating to the Premises. Tenant shall immediately cure any violation of an Accessibility Law occurring upon the Premises that results from any violation by Tenant of any provision of this Section 28.k. and shall bear all costs and expenses of performing the duties required hereunder. Tenant shall reimburse Landlord upon demand for any cost or expense required to alter any portion of the Premises to comply with any Accessibility Law as a result of any Tenant Alteration. Notwithstanding any contrary provision of this Section 28.k., Landlord shall have no obligation to approve any Tenant Alteration if Landlord, in its sole discretion exercised in good faith, determines that such Tenant Alteration would obligate Landlord to make alterations of or additions to any part of the Premises, Building or Project in order to comply with any Accessibility Law, unless Tenant agrees to make such alterations or additions at Tenant's cost and expense. If any claim is asserted against Landlord under any Accessibility Law relating directly or indirectly to any violation by Tenant of any of the provisions of this Section 28.k., Tenant shall defend, indemnify and hold Landlord harmless from and against any claims, charges, liabilities, obligations, penalties, damages, judgments, costs and expenses (including attorney's fees) arising directly or indirectly from such violation. Nothing contained herein shall be deemed to be a warranty or representation by Landlord that the Project complies with all Accessibility Laws.

l. Submission of Lease. Submission of this Lease for examination, even though executed by Tenant, shall not bind Landlord in any manner, and no Lease or other obligation on the part of the Landlord shall arise, until this Lease is executed and delivered by Landlord to Tenant.

m. Recording. Tenant shall not record this Lease without the prior written consent of Landlord.

n. Signatures. This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which together shall constitute one and the same instrument. This Agreement may be signed by facsimile transmission, by electronic signature or by scanned and emailed PDF, JPEG or TIF signatures.

**29. HAZARDOUS AND TOXIC WASTE MATERIALS.**

(a) Claim shall mean and include any demand, cause of action , proceeding or suit (i) for damages (actual or punitive), losses, injuries to person or property, damages to natural resources, fines, penalties, interest, contribution or settlement, (ii) for the cost of site investigations, feasibility studies, information requests, health or risk assessments or Response actions, and (iii) for enforcing insurance, contribution or indemnification agreements.

(b) Environmental Laws shall mean and include all existing and future federal, state and local statutes, ordinances, regulations and rules relating to environmental quality, health, safety, contamination and clean-up, including, without limitation, the Clean Air Act, 42 U.S.C. Section 7410 et seq.; the Clean Water Act, 33 U.S.C. Section 1251 et seq., and the Water Quality Act of 1987; the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), 7 U.S.C. Section 136 et seq.; the Marine Protection, Research, and Sanctuaries Act, 33 U.S.C. Section 1401 et seq.; the National Environmental Policy Act, 42 U.S.C. Section 4321 et seq.; the Noise Control Act, 42 U.S.C. Section 4901 et seq.; the Occupational Safety and Heath Act, 29 U.S.C. 651 et seq.; the Resource Conservation and Recovery Act (RCRA), 42 U.S.C. Section 6901 et seq., as amended by the Hazardous and Solid Waste Amendments of 1984; the Safe Drinking Water Act, 42 U.S.C., Section 300f et seq.; the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), 42 U.S.C. Section 9601 et seq., as amended by the Superfund Amendments and Reauthorization Act; the Emergency Planning and Community Right-to-Know-Act, and the Radon Gas and Indoor Air Quality Research Act; the Toxic Substances Control Act (TSCA), 15 U.S.C. Section 2601 et seq.; the Atomic Energy Act, 42 U.S.C. Section 2011 et seq., and the Nuclear Waste Policy Act of 1982, 42 U.S.C. Section 10101 et seq.; and the environmental protection and policy laws and hazardous waste and substance laws enacted by the State of Washington, and the State of Washington superlien and environmental clean-up statutes, with implementing regulations and guidelines. Environmental Laws shall also include all existing and future state, regional, county, municipal and other local laws, regulations and ordinances insofar as they are equivalent or similar to the federal laws recited above or purport to regulate Hazardous Materials.

(c) Hazardous Materials shall mean and include the following, including mixtures thereof; any hazardous substance, pollutant, contaminant, waste, by-product or constituent regulated under CERCLA; oil and petroleum produces and natural gas, natural gas liquids, liquefied natural gas and synthetic gas usable for fuel; pesticides regulated under the FIFRA; asbestos and asbestos-containing materials, PCB's and other substances regulated under the TSCA; source material, special nuclear material, by-product material and any other radioactive materials or radioactive wastes, however produced, regulated under the Atomic Energy Act or the Nuclear Waste Policy Act; chemicals subject to the OSHA Hazard Communication Standard, 29 C.F.R. Section 1910.1200 et seq.; and industrial process and pollution control wastes, whether or not hazardous within the meaning of RCRA, together with any and all other hazardous or toxic materials regulated from time to time under any other Environmental Laws.

(d) Manage means to generate, manufacture, process, treat, store, use, re-use, refine, recycle, reclaim, blend or burn for energy recovery, incinerate, accumulate speculatively, transport, transfer, dispose of or abandon Hazardous Materials.

(e) Release or Released shall mean any actual or threatened spilling, leaking, pumping, pouring, emitting, emptying, discharging, injecting, escaping, leaching, dumping or disposing of Hazardous Materials into the environment, as environment is defined in CERCLA.

(f) Response or Respond shall mean action taken in compliance with Environmental Laws to correct, remove, remediate, clean-up, prevent, mitigate, monitor, evaluate, investigate, assess or abate the Release of a Hazardous Material.

29.1 Tenant's Obligations with Respect to Environmental Matters. During the term of this Lease: (a) Tenant shall at its own cost comply with all Environmental Laws; (b) Tenant shall not conduct or authorize the management of any Hazardous Materials on the Premises, the Building or the Project, including installation of any underground storage tanks, without prior written disclosure to and approval by Landlord; (c) Tenant shall not take any action that would subject the Premises, the Building or Project to permit requirements under RCRA or any other Environmental Laws for storage, treatment or disposal of Hazardous Materials; (d) Tenant shall not dispose of Hazardous Materials in dumpsters (if any) provided by Landlord for Tenant use; (e) Tenant shall not discharge Hazardous Materials into drains or sewers: (f) Tenant shall not cause or allow the Release of any Hazardous Materials on, to or from the Premises; and (g) Tenant shall at its own cost arrange for the lawful transportation and off-site disposal of all Hazardous Materials that Tenant generates.

29.2 Copies of Notices. During the term of this Lease, Tenant shall promptly provide Landlord with copies of all summons, citations, directives, information inquiries or requests, notices of potential responsibility, notice of violation or deficiency, orders or decrees, claims, complaints, investigations, judgments, letters, notices of environmental liens or Response actions in progress and other communications, written or oral, actual or threatened, from the United States Environmental Protection Agency, Occupational Safety and Health Administration, State of Washington Environment Protection Agency or other federal, state or local agency or authority, or any other entity or individual, concerning (a) any Release of a Hazardous Material on, to or from the Premises; (b) the imposition of any lien on the Premises; or (c) any alleged violation of or responsibility under Environmental Laws. Landlord and Landlord's agents, contractors, beneficiaries and employees (and the agents, employees or representative of any such parties) shall have the right to enter the Premises and conduct appropriate inspections or tests in order to determine Tenant's compliance with Environmental Laws.

29.3 Tests and Reports. Upon written request by Landlord, Tenant shall provide Landlord with the results of appropriate reports and tests, with transportation and disposal contracts for Hazardous Materials, with any permits issued under Environmental Laws, and with any other applicable documents to demonstrate that Tenant complies with all Environmental Laws relating to the Premises, and if such reports, tests or other items reveal any failure of the Premises to so comply with all Environmental Laws, then, in addition to other rights and remedies of Landlord hereunder, Tenant shall reimburse Landlord, upon demand, for the cost of such reports, tests and other investigations.

29.4 Access and Inspection. Landlord and its agents and representatives shall have access to the Premises and to the books and records of Tenant (and any occupant of the Premises claiming by, through or under Tenant) relating to Hazardous Materials for the purpose of ascertaining the nature of the activities being conducted thereon and to determine the type, kind and quantity of all products, materials and substances brought onto the Premises or made or produced thereon. Landlord and its agents and representatives shall have the right to take samples in quantity sufficient for scientific analysis of all products, materials, and substances present on the Premises, including, but not limited to, samples of products, material or substances brought onto or made or produced on the Premises by Tenant or any occupant claiming by, through or under Tenant or otherwise present on the Premises. And, further, notwithstanding any provision of this Lease or applicable statutes or judicial decisions to the contrary, with respect to any assignment, subletting, grant of license, concession or any other permission to use the Premises by any person other than Tenant, Landlord shall have the right to withhold Landlord's consent thereto if, in Landlord's sole judgment and discretion, the assignee, subtenant, licensee, concessionaire or such other person is not capable of performing or is not sufficiently qualified to perform in accordance with the requirements of this Article 29. Any assignment sublease, license or other permission to use the Premises from which the Landlord withholds its consent as provided in this Section 29.4 shall be voidable at the Landlord's sole option.

29.5 Tenant's Obligation to Respond. If Tenant's Management of Hazardous Materials at the Premises (i) gives rise to liability or to a claim under any Environmental Law (ii) causes a significant public health effect, or (iii) creates a nuisance, Tenant shall promptly take all applicable action in Response.

29.6 Indemnification. Tenant shall indemnify, defend and hold harmless Landlord, its

beneficiaries, its lenders, any managing agents and leasing agents of the Premises, and their respective beneficiaries, agents, partners, officers, directors and employees, from all claims arising from or attributable to: (a) the presence of Hazardous Materials in or on the Premises (or, as a result of Tenant's use of the Premises, in or on the Building or Project or the subsurface thereof) or the violation of any Environmental Laws (including, without limiting the generality thereof, any cost, claim, liability or defense expended in remediation required by a governmental authority or by reason or the release, escape, seepage, leakage, discharge or migration of any Hazardous Material on or from the Premises or violation of an Environmental Laws), or (b) any breach by Tenant of any of its warranties, representations or covenants in this Section. Tenant's obligations hereunder shall survive the termination or expiration of this Lease.

IN WITNESS whereof, Landlord and Tenant have executed this Lease as of the date first written above.

| | |
|---|---|
| Landlord: **Omni Building, LLC** | Tenant: **New Care Concepts, Inc.,** a Washington corporation |
| By: _____ | By: _____ |
| Printed Name | Robert Thomas<br>Printed Name |
| Title: VP | Title: President |
| 6-16-14<br>Date | 6/11/14<br>Date |

STATE OF WASHINGTON )
)ss.
COUNTY OF KING )

On this 16th day of June, 2014, before me, a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared **Jeffrey W. Stock** known to me to be the Managing Member of the Limited Liability Company named in and which executed the foregoing instrument, and state on oath that he is authorized to execute the foregoing instrument on behalf of said company and signed the same as the free and voluntary act and deed of said company for the uses and purposes therein mentioned.

BARBARA J. JENKINS
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
AUGUST 5, 2017

Barbara J. Jenkins
Print Name: Barbara J. Jenkins
Notary Public in and for the
State of Washington at Kent
My appointment expires: 8-5-17

STATE OF OREGON )
)ss.
COUNTY OF ~~WASHINGTON~~ Clackamas )

On this 11 day of June, 2014, before me a Notary Public in and for the State of Oregon, duly commissioned and sworn, personally appeared Robert Thomas, known to me to be the President of the corporation named herein and which executed the foregoing instrument, and state on oath that he is authorized to execute the foregoing instrument on behalf of said corporation and signed the same as the free and voluntary act and deed of said corporation for the uses and purposes therein mentioned.

OFFICIAL SEAL
LYNNETTE MARIE FABER
NOTARY PUBLIC-OREGON
COMMISSION NO. 472967
MY COMMISSION EXPIRES OCTOBER 28, 2016

Lynnette Marie Faber
Print Name: Lynnette Marie Faber
Notary Public in and for the
State of Oregon
My appointment expires: 10/28/2016

**EXHIBIT "A"**

**LEGAL DESCRIPTION OF PROJECT**

Lot 15, West Campus Business Park, Volume 97, Page 78,
King County, Washington

**EXHIBIT "B"**

**RULES AND REGULATIONS**
Attached to and made a part of the Lease

1. The washroom, partitions, mirrors, washbasins, and other plumbing fixtures shall not be used for any purpose other than those for which they were constructed, and no sweeping, rubbish, rags, or other substances shall be thrown therein. All damage resulting from any misuse of such items shall be borne by the Tenant who, or whose servants, employees, agents, visitors, or licensees, shall have caused the same.

2. No bicycles, vehicles, vending machines, or animals of any kind shall be brought into or kept in or about the premises, and no cooking shall be done or permitted by any Tenant on the premises except that the preparation of coffee, tea, hot chocolate, microwavable food and similar items for the Tenant and its employees and business visitors, shall be permitted. No Tenant shall cause or permit any unusual or objectionable odors to escape from the premises.

3. No furniture, freight, or equipment of any kind shall be brought into the building without prior notice to the Landlord, and all moving of the same into or out of the building shall be done at such time and in such a manner as the Landlord shall designate. The Landlord shall have the right to prescribe the weight, size, and position of all safes and other heavy equipment brought into the building. Safes or other heavy objects shall, if considered necessary by the Landlord, stand on supports of such thickness as is necessary to properly distribute the weight. The Landlord will not be responsible for loss of or damage to any such safe or property from any cause, and all damage done to the building by moving or maintaining any such safe or other property shall be repaired at the expense of the Tenant.

4. The premises shall not be used for the storage of merchandise except as such storage may be incidental to the use of the premises for general office purposes. No Tenant shall occupy or permit any portion of his premises to be occupied for the manufacture or sale of liquor, narcotics, or tobacco in any form. The premises shall not be used for lodging or sleeping or for any illegal purposes.

5. The Tenant shall maintain the Premises in an attractive, first-class operative condition at all times (includes centrally-utilized areas – reception, utility, conference room(s), break room and corridor equipment).

6. All doors opening into public corridors shall be kept closed.

7. Canvassing, soliciting, and peddling in the building are prohibited, and each Tenant shall cooperate to prevent the same.

8. Tenants using doors after hours are responsible for locking after ingress and egress.

9. Individual suite doors are to be locked at all times in Tenant's absence. The Landlord will not be responsible for loss or damage in such an instance.

10. Chair mats are required for every desk in the suite. Tenant is responsible for providing their own chair mats.

11. The Tenant may not smoke on the premises at any time. If you choose to smoke, you must do so outside in the designated smoking area.

12. The Tenant is responsible for reading memos that pertain to Omni Properties, Inc. If the memos are not read, the Landlord is in no way responsible for misunderstandings, misinterpretations, misinformation, confusion, or costs associated with changes that occur.

13. The Tenant shall not use or keep on the premises or in the building any kerosene, gasoline, flammable, or combustible fluid or material, or use any method of heating or air conditioning other than that supplied by the Landlord.

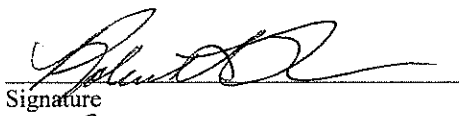
14. The Landlord reserves the right to exclude or expel from the building or premises any person who, in the judgment of the Landlord, is intoxicated or under the influence of liquor or drugs, or who shall in any manner do any act in violation of any of the rules and regulations of the building.

15. The Landlord shall have the right, exercisable without notice and without liability to Tenant, to change the name and street address of the building of which the premises are a part.

16. The Landlord shall have the right to control and operate those portions of the building other than the Premises, and the public facilities, and heating and air conditioning, as well as facilities furnished for the common use of the Tenants, in such manner as it deems best for the Tenants generally.

17. The Tenant shall not install any equipment of any kind which uses electric current, except for computers, printers, calculators, radios, and other ordinary low-current devices, without the prior written approval of the Landlord. In the event the installation of equipment using excessive electric current is approved by the Landlord, the Tenant agrees to pay to the Landlord each month a fair and reasonable amount, mutually agreed to by the Tenant and Landlord, to cover the additional utility expense.

18. In the event of invasion, mob, riot, public excitement, or other commotion, the Landlord reserves the right to restrict or prevent access to the building during any period of the threat of, commencement, or continuance of any such activity, and for that purpose shall have the right to secure the access to the premises and to take all other reasonable measures to protect the building, the Tenants and their invitees, and employees, and the property in the building.



Signature

Date: 7/10/14

Robert L. Thomas

Printed Name

**EXHIBIT "C"**

**THE PREMISES**

1. **Abated Rent.** Rent shall be abated for the months of September 2014 through January 2015.

2. **Tenant Improvements.** Landlord shall provide a turnkey tenant improvement based upon the space plan provided by Landlord's architect as shown on the attached floor plan, including a dishwasher in the break room, core drill for conference room table, electrical outlet for flat panel TV, and vented door in server room with HVAC intake/outtake.

3. **Project Operating Costs.** Tenant shall pay its share of any increase in the actual operating costs of the Building on a pro-rata basis, predicated upon a 2014 base year method of expense calculation ("Base Year"). All operating expenses shall be based upon the Building being 100% occupied and fully assessed for real estate taxes with all tenants paying full rent, as contrasted with free rent, half rent and the like If required, Tenant shall receive four percent (4%) annual cumulative and compounding cap on controllable operating expenses (taxes, insurance and utilities are deemed non-controllable).

Tenant shall be permitted to audit Landlord's records as they relate to the operating expenses and (if any) increases.

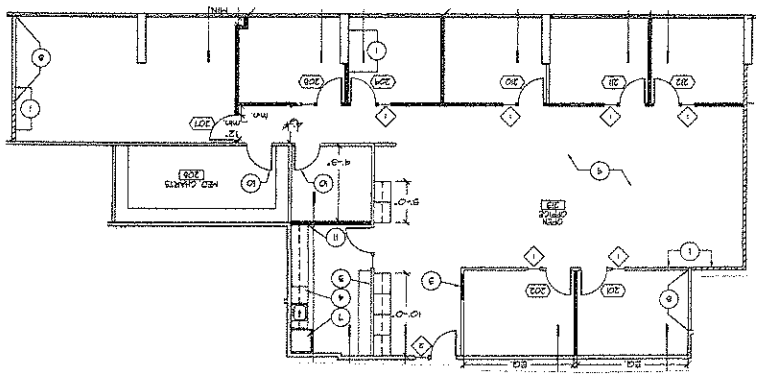
4. **Option to Renew.** Upon six (6) months' prior written notice to Landlord, Tenant shall have the right to extend the Lease for one additional term of five (5) years at fair market rent.

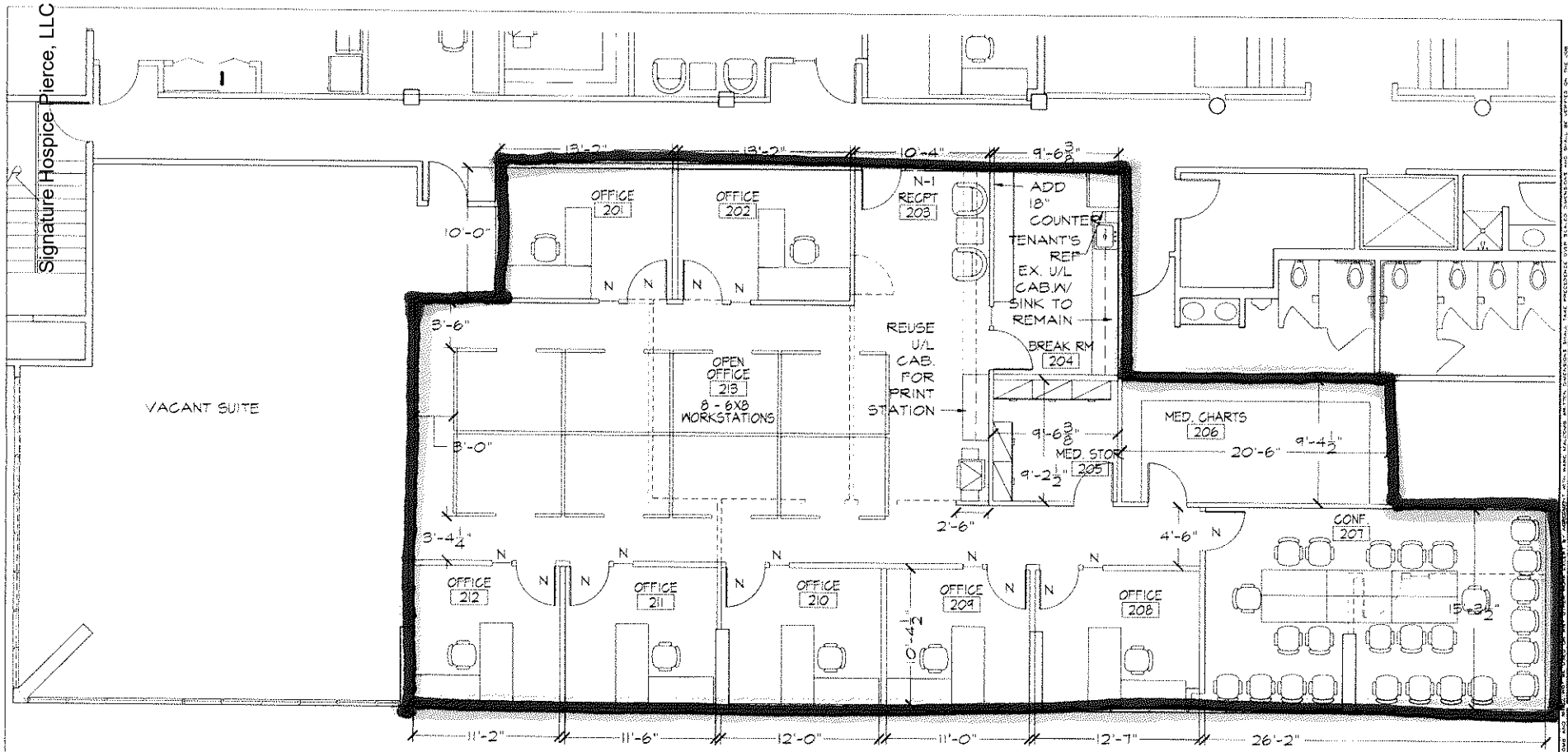
5. **Termination Option:** Tenant shall have the option to terminate this lease one (1) time after the end of the third lease year. Tenant shall give written notice of its intention to exercise the Termination Option six (6) months prior to the effective date. In the event the Termination Option is exercised, Tenant shall pay the Landlord a termination fee in the amount of $36,300 including unamortized tenant improvement costs of $27,800 and commission fees of $8,500.

6. **Restoration.** Per the plan provided by Landlord's architect and agreed to by Tenant, Tenant will have no obligation to restore any approved improvements made to the leased premises at the end of the lease term or any extensions thereafter with the exception of all low voltage cabling installed by Tenant, which shall be removed by Tenant at the end of the lease term.

7. **Relocation of Premises.** Landlord shall not have the right to relocate Tenant.

8. **Representation.** Tenant is exclusively represented by Cresa and Washington Partners. Cresa and Washington Partners shall be paid a standard market commission by Landlord in the amount of 5% of the total lease consideration. Fifty percent (50%) of the commission shall be due and payable upon execution of the Lease between Landlord and Tenant and the balance on occupancy. The listing agent, Mark Clirehugh of Kidder Mathews, is being paid a real estate commission by the Landlord.






## DEMO./ PARTITION PLAN

SCALE: 1/8" = 1'-0"

## LEGEND

DEMOLITION

EXISTING PARTITION TO REMAIN.

NEW PARTITION

B/S 1'-6" x FULL HEIGHT RELITE IN B/S FRAME. (N)

B/S 1'-6" x FULL HEIGHT rRATED RELITE IN RATED FRAME (N-1)

THIS LAYOUT IS FOR PLANNING PURPOSES ONLY AND NOT INTENDED FOR CONSTRUCTION. THE DESIGN APPROACH SHOWN HERE IS SUBJECT TO ADJUSTMENTS AND CHANGES DUE TO ACTUAL SPACE CONDITIONS, SUCH AS EXISTING STRUCTURAL ELEMENTS, OR MECHANICAL, ELECTRICAL AND PLUMBING SYSTEM REQUIREMENTS. INTERIOR ROOM SIZES ARE APPROXIMATE. FURNITURE AND BUILT-INS ARE SHOWN AS DESIGN SUGGESTIONS ONLY, AND ARE NOT THE RESPONSIBILITY OR OBLIGATION OF THE OWNER OR CONNELL DESIGN.

CONNELL DESIGN
A WALTER MALCOMB COMPANY

**Signature Home Health**
**Omni Properties**
**Second Floor**
**Federal Way, Washington**

| DATE | REMARKS |
|---|---|
| 4.1.14 | REVIEW 1 |

PM: VSS
DRAWN BY:
JOB NO.: 14-058

SHEET
**SP-A**

# AMENDMENT #1 TO LEASE

AGREEMENT ("Agreement") made as of this 15th day of November 2017, between **Omni Building, LLC,** having its principal place of business at 33926 – 9th Avenue South, Federal Way, Washington 98003 ("Landlord"), and **New Care Concepts, Inc.,** a Washington corporation, having its place of business at 909 S. 336th Street, Suite 202, Federal Way, Washington 98003 ("Tenant").

WITNESSETH:

WHEREAS, Landlord and Tenant have entered into a certain lease dated June 11, 2014, and as further amended by this agreement.

WHEREAS, Tenant desires to extend the lease for a period of forty-nine (49) months and relocate to Suite 100, under the following terms and conditions:

## AGREEMENT

NOW, THEREFORE, in consideration of the covenants and agreements contained herein, the parties hereby mutually agree as follows:

1. **Extend Term.** Notwithstanding anything to the contrary contained in the Lease, the term of the Lease is hereby extended for forty-nine (49) months, commencing February 1, 2020, and expiring on February 29, 2024.

2. **Relocation of Premises.** Effective on or after December 1, 2017, or upon Landlord's completion of the Tenant Improvements, Tenant shall relocate from Suite 202 to Suite 100, 4,468 rentable square feet (Exhibit A).

3. **Base Rent**. The "Base Rent" for the Premises shall be:

| | |
|---|---|
| 12/1/17 – 12/31/17 | $4,623.00 per month whether in Ste. 202 or Ste. 100 |
| 1/1/18 – 1/31/18 | Rent abated |
| 2/1/18 – 1/31/19 | $6,000.00 per month |
| 2/1/19 – 1/31/21 | $6,400.00 per month |
| 2/1/21 – 1/31/23 | $6,700.00 per month |
| 2/1/23 – 2/29/24 | $7,000.00 per month |

4. **Premises Percent**. Lessee's percentage share for Suite 100 is 11.45% (.1145).

5. **Lease Deposit.** Tenant's security deposit of $4,854.00 shall be carried forward and Tenant shall deposit $2,146.00 with Landlord to increase the total security deposit to $7,000.00.

6. **Rental Abatement.** Rent shall be abated for the month of January 2018.

7. **Tenant Improvements.** Landlord will paint and carpet Suite 100, move relight in existing conference room to allow construction of wall to divide into two offices and provide locking door knobs on private offices as required by Tenant at Landlord's expense.

8. **Full Force and Effect**. Except as expressly modified above, all terms and conditions of the Lease remain in full force and effect and are hereby ratified and confirmed.

LANDLORD: **Omni Building, LLC**

Printed Name: Jeff Stark

Date: 11/20/17

TENANT: **New Care Concepts, Inc.,**
a Washington corporation

Printed Name: Robert Thomas

Date: 11/15/17

STATE OF WASHINGTON )
)ss
COUNTY OF KING )

On this 20th day of November, 2017, before me a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared Jeffrey W. Stack, known to me to be the President of the corporation named herein and which executed the foregoing instrument, and stated on oath that he is authorized to execute the foregoing instrument on behalf of said corporation and signed the same as his free and voluntary act and deed of said corporation for the uses and purposes therein mentioned.

BARBARA J JENKINS
NOTARY PUBLIC
STATE OF WASHINGTON
COMMISSION EXPIRES
08-05-21

Barbara J. Jenkins
Print Name: Barbara J. Jenkins
Notary Public in and for the State of Washington,
residing at Kent
My appointment expires: 8-5-21

OFFICIAL STAMP
KELSEY LYNN MARGHEIM
NOTARY PUBLIC - OREGON
COMMISSION NO. 966222
MY COMMISSION EXPIRES SEPTEMBER 06, 2021

STATE OF Oregon )
)ss
COUNTY OF Washington )

On this 15 day of November, 2017, before me a Notary Public in and for the State of Washington, duly commissioned and sworn, personally appeared Robert Thomas, known to me to be the _____ of the corporation named herein and which executed the foregoing instrument, and state on oath that he is authorized to execute the foregoing instrument on behalf of said corporation and signed the same as his free and voluntary act and deed of said corporation for the uses and purposes therein mentioned.

Kelsey Marghem
Print Name: Kelsey Marghem
Notary Public in and for the State of Oregon,
residing at Wilsonville
My appointment expires: September 6, 2021

**Exhibit "A"**

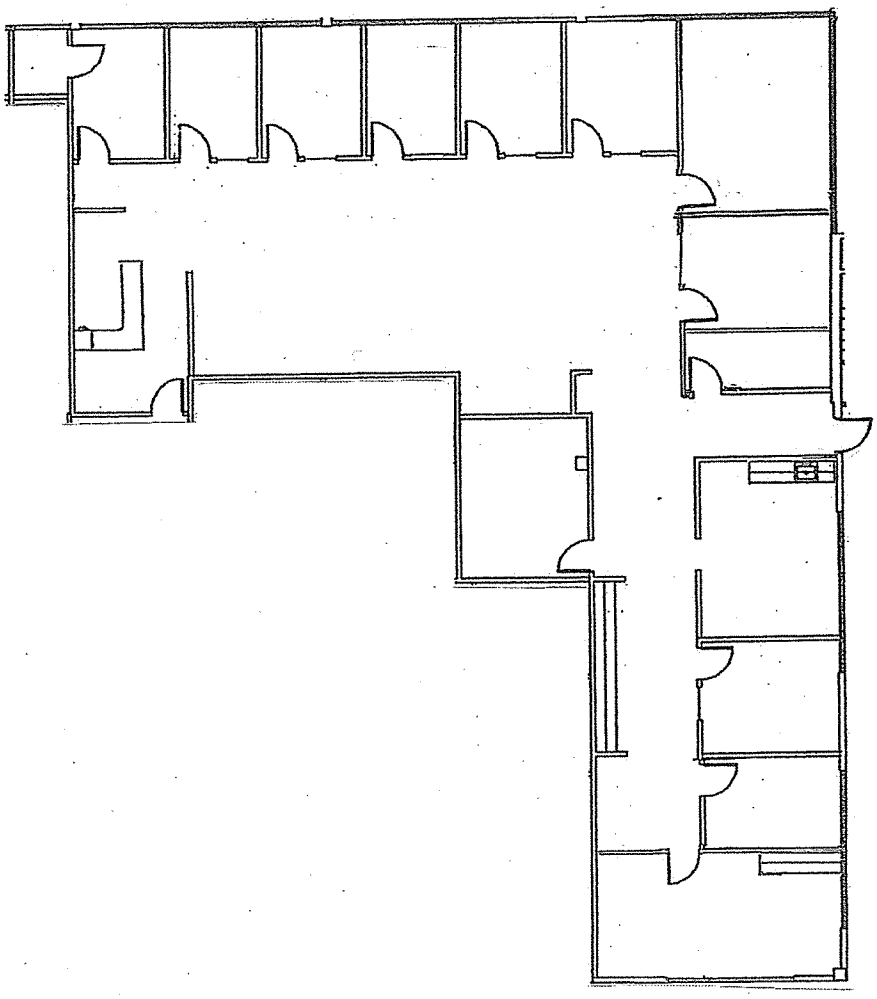


**EXHIBIT 16: Northwest Hospice, LLC Bank Letter**

Signature Hospice Pierce, LLC

KeyBank

1211 SW 5th Ave, Ste 500
Portland, OR 97204

November 13, 2020

To Whom It May Concern:

At the request of our client Northwest Hospice LLC, the following reflects their Key Bank checking account information:

ABA Routing / Transit Number:
Account Number:
Account Name: Northwest Hospice LLC
Current Account Balance: $809,294.45

The account is in good standing. Should you have questions or concerns, please do not hesitate to contact me at 503-790-7553.

Regards,

Kevin Yu
Sr. Treasury Service Client Manager
KeyBank Enterprise Commercial Payments
Real Estate Capital Treasury Services
Kevin_Yu@KeyBank.com
Phone: 503-790-7553

**EXHIBIT 17: Letter of Financial Commitment**

SIGNATURE healthcare at home
care where you are

January 5, 2021

Department of Health
Certificate of Need Program
111 Israel Road SE
Tumwater, WA 98501

Re: Signature Hospice Pierce, LLC Letter of Commitment

To Whom It May Concern:

The Certificate of Need Hospice Application asks for a financial Letter of Commitment from the hospice agency seeking Medicare certification.

As the Chief Financial Officer of Signature Group, LLC, the ultimate parent of Signature Hospice Pierce, LLC, please consider this letter a commitment of Signature Group, LLC (through its wholly owned subsidiary Northwest Hospice, LLC) to provide the financial capital needed to fund the launch and operations of Signature Hospice Pierce, LLC in Pierce County, if the application is approved.

A Bank Letter stating the funds available in Northwest Hospice, LLC's bank account has also been provided to show evidence of our ability to fund this crucial project.

Sincerely,

DocuSigned by:
92CF1B9974B94B2...

Ron Odermott, CPA
Chief Financial Officer
503-783-2489
rodermott@avamere.com

**EXHIBIT 18: Line of Credit letter**

January 27, 2021

To Whom it May Concern,

Signature Hospice Pierce, LLC and its parent company Signature Group, LLC are newly formed entities and therefore do not have historical audited financial information. Signature Group, LLC is the parent company of all Signature Home Health and Hospice agencies.

Signature Hospice Pierce, LLC will be funded with existing cash, see attached bank letter, and has an existing accounts receivable borrowing base line of credit. The line of credit is with Midcap Funding IV Trust and has a maximum available borrowing of $11,000,000. Signature Hospice Pierce, LLC will have access to this line of credit for short term operational needs.

Sincerely,

DocuSigned by:
92CF1B9974B94B2...

Ron Odermott, CPA

Chief Financial Officer

Avamere Health Services, LLC

503-783-2489

rodermott@avamere.com

**EXHIBIT 19: Homecare Homebase Staffing Matrix**

# 2017 BRANCH STAFFING MATRIX - *Hospice*

| STAGE | HS ADC RANGE | TOTAL STAFF | BD | CFSS | IC | MRS | PSC | AS/HRD | Volunteer Coordinator | Bereavement Coordinator |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0 - 20 | 2.5 | 1 | | | | 1 | | 0.25 | 0.25 |
| 2 | 21 - 40 | 3.5 | 1 | 1 | | | 1 | | 0.25 | 0.25 |
| 3 | 41 - 60 | 5.0 | 1 | 1 | | 1 | 1 | | 0.50 | 0.50 |
| 4 | 61 - 80 | 6.0 | 1 | 1 | | 1 | 1 | 1 | 0.50 | 0.50 |
| 5 | 81 - 110 | 7.0 | 1 | 2 | | 1 | 1 | 1 | 0.50 | 0.50 |
| 6 | 111-130 | 8.5 | 1 | 2 | | 1 | 1 | 2 | 0.75 | 0.75 |
| 7 | 131-160 | 9.5 | 1 | 2 | | 1 | 2 | 2 | 0.75 | 0.75 |
| 8 | 161-190 | 10.5 | 1 | 3 | | 1 | 2 | 2 | 0.75 | 0.75 |
| 9 | 191-220 | 12.0 | 1 | 3 | | 2 | 2 | 2 | 1.00 | 1.00 |
| 10 | 221-250 | 13.0 | 1 | 3 | 1 | 2 | 2 | 2 | 1.00 | 1.00 |

PSC should be LN

| Positions | | Descriptions |
|---|---|---|
| **BD** | Branch Director | Oversees office/clinical services, supervises all back office & field employee; provides aide in-services, chart audits, AP, hiring, orientation, timely billing. |
| **CFSS** | Clinical Field Staff Supervisor | Order review/approval, case conference, addresses ReCert/DC decisions, ensure coordination of care. |
| **IC** | Intake Coordinator | Responsible for entering and management referrals; scanning in attachments; follow-up with scheduling to ensure assessment visit scheduled timely |
| **PSC** | Patient Services Coordinator | Maintains patient schedules, on-call notebook, hospitalization log, scheduling supervisory visits. |
| **MRS** | Medical Records Specialist | Process signed/unsigned orders & 485s; scans into EMRs. |
| **AS/HRD** | Administrative Specialist / Human Resource Designee | Receives/directs incoming calls; orders office supplies; processes AP; assist with car stock supplies; serves as HR designee. |
| **VC** | Volunteer Coordinator | Orientation, training, & coordination of all Hospice volunteers and for volunteer program administration |
| **BC** | Bereavement Coordinator | Develops, implements, & supervises the hospice bereavement program, working closely with the BD and VC. |

| Additional Functions | | Responsibilities Assigned to an Existing Back Office Staff Member |
|---|---|---|
| **PC** | Payroll Coordinator | Processes bi-weekly payroll for the branch. |
| **MES** | Medical Equipment Specialist | Device expert who can assist in troubleshooting handheld devices for the field staff. |
| **CCPP** | Company Car Point Person | Manages the Company Car Program at the local level in conjunction with BD. |

## 2017 FIELD STAFFING MATRIX - *Hospice*

| STAGE | Hospice ADC | TOTAL STAFF | RN | LN | MSW | CH | MD | HHA | RD | AN | On Call RN *(Additional staff)* | | Maximum # Certified Preceptors *(NOT additional staff)* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 0-25 | 5 | 2 | PRN | 1 | 1 | 0.25 | 1 | PRN | 0 | 0 | | 1 |
| 2 | 26-40 | 10 | 3 | 1 | 1 | 1 | 0.25 | 3 | PRN | 1 | 0 | | 2 |
| 3 | 41-60 | 12 | 3 | 1 | 1 | 1 | 0.25 | 4 | PRN | 1 | 1 | | 3 |
| 4 | 60-90 | 15 | 4 | 1 | 1 | 1 | 0.5 | 6 | PRN | 1 | 1 | | 3 |
| 5 | 91-120 ( 2 teams) | 23 | 6 | 1 | 2 | 2 | 0.5 | 9 | PRN | 1 | 2 | | 4 |
| 6 | 121-150 | 30 | 8 | 2 | 2 | 2 | 0.5 | 12 | PRN | 2 | 2 | | 4 |
| 7 | 151-180 | 36 | 10 | 2 | 2 | 2 | 0.5 | 15 | PRN | 2 | 3 | | 5 |
| 8 | 181-210 (3 teams) | 45 | 12 | 3 | 3 | 3 | 0.75 | 18 | PRN | 3 | 3 | | 5 |
| 9 | 211-240 | 52 | 15 | 3 | 3 | 3 | 0.75 | 21 | PRN | 3 | 4 | | 6 |
| 10 | 241-270 (4 teams) | 61 | 17 | 3 | 4 | 4 | 0.75 | 24 | PRN | 4 | 5 | | 7 |
| 11 | 271-300 | 67 | 19 | 4 | 4 | 4 | 1 | 27 | PRN | 4 | 5 | | 8 |

### Notes

RN and HHA totals determined by using the lower number in the ADC range to determine staffing
Can be adapted to the RN/LN model by using a ratio of 1 RN to 24 patients and adding a LN for every RN position
MSW and Chaplain (CH) numbers do not include duties as a Volunteer Coordinator (VC) or Bereavement Coordinator (BC)
Be proactive with hiring PRN staff at all stages, especially with MSW, CH, and HHAs, especially in Stages 1 & 2 for MSW & CH as they are core members
RD = Registered Dietician; AN = Admitting Nurse

### Assumptions

75% of visits to be done by FT staff

| | |
|---|---|
| RN/Patient ratio is 1:14 | 1:10 without On Call and Admission Nurse |
| HHA/Patient ration is 1:10 | almost every patient will be assigned a HHA |
| Team size is 45-60 | new team added at stage 4 includes an additional CFSS |
| | new team added at stage 8 includes an additional CFSS |
| | new team added at stage 10 includes an additional CFSS |

FT LN added with each new team. LN to provide PDO coverage for RN case managers, patient visits during weekly IDG meeting, staff continuous care shifts as needed

On Call: numbers reflect dedicated weekend staff only  No On Call staff added for week nights

**EXHIBIT 20: Copy of Dr.Floyd Sekeramayi MD License**

STATE OF WASHINGTON

# DEPARTMENT OF HEALTH

*Olympia, Washington 98504*

1/20/2021

Subject: Credential Verification

To Whom It May Concern:

This verifies the status of the Physician And Surgeon License for Sekeramayi, Floyd .

This site is a Primary Source for Verification of Credentials.

| | |
|---|---|
| **Credential Number:** | MD60300185 |
| **Credential Type:** | Physician And Surgeon License |
| **First Credential Date:** | 02/19/2014 |
| **Last Renewal Date:** | 10/05/2020 |
| **Credential Status:** | ACTIVE |
| **Current Expiration Date:** | 08/03/2022 |
| **Enforcement Action:** | No |

The Washington Department of Health presents this information as a service to the public.

The absence or presence of information in this system does not imply any recommendation, endorsement, or guarantee of competence of any health care professional, the mere presence of such information does not imply a practitioner is not competent or qualified.

This site provides disciplinary actions taken and credentials denied for failure to meet qualifications. If the Enforcement Action is listed as a No, there has been no disciplinary action. It allows viewing and downloading of related legal documents since July 1998. Contact our Public Disclosure Office at pdrc@doh.wa.gov for information on actions before July 1998. This information comes directly from our database. It is updated daily.

## EXHIBIT 21: Medical Director Job Description

**JOB TITLE/POSITION:** Hospice Medical Director

**REPORTS TO:** **Administrator**

## JOB DESCRIPTION SUMMARY:

The Hospice Medical Director will direct and supervise the clinical operations of the assigned Hospice agency(ies) assuming overall responsibility for the medical component of the patient care. He/she is responsible for providing clinical leadership and expertise to the hospice IDG for the purpose of improving patient medical care and palliation. The role is responsible for facilitating a culture of collaboration among all medical and nursing staff involved with hospice patient care.

The Hospice Medical Director will be dedicated to the Mission, Values and Care Commitments of SIGNATURE HOSPICE and embrace and demonstrate our mission: "To Enhance the Life of Every Person We Serve."

## ESSENTIAL JOB FUNCTIONS / RESPONSIBILITIES:

- Reviews, coordinates and oversees the management of the medical services for a hospice program and care for hospice patients, which includes, but is not limited to, medical diagnosis, prognosis, medications, procedures and clinical course.
- Supervises and provides guidance for services provided by other hospice physicians under contract or employed by the agency.
- Provides consultation for palliative and end-of-life care issues.
- Reviews patient eligibility for services including admission and recertification.
- Facilitates communications and works effectively between Signature Hospice employees/volunteers, patients/families/caregivers, physicians, vendors, and other departments, and professionals as appropriate.
- Reviews and evaluates cases through a variety of means such as home visits, conferences, and record reviews; consults with patient's attending physician as needed and appropriate.
- Provides hospice services directly to patients in the patient's home or other setting, including, but not limited to, a nursing facility, assisted living facility, residential care facility, or adult foster home, that is considered to be the patient's home and/or in a hospice in-patient facility, as needed and appropriate.
- Completes, maintains and submits/synchronizes accurate and relevant clinical notes and electronic documents regarding patient's condition and care given. Records pain/symptom management changes/outcomes as appropriate.
- Reviews and signs medication/procedure orders, certification/re-certification of terminal illness orders, changes in level of care and any other supplemental orders as indicated and allowed/required by State and Federal guidelines
- Maintains comprehensive working knowledge of State and federal medical practice regulations and hospice standards; serves as a resource for appropriate organization personnel and community medical personnel.
- Be responsible for assuring that established policies, by-laws, rules and regulations of the organization are followed in the program.
- Assists and supports QAPI committee with identifying quality indicators, proposing

implementation of programs to address identified indicators and evaluating and monitoring outcome measures for effective care.
- Reviews, accepts and abides by the Signature Hospice Medical Staff By-Laws.
- Adheres to all policies, standards and State and federal regulations regarding patient care, conduct, safety, infection control, fire, security and risk management.
- Performs in a cost-effective manner with respect to utilization of organization resources.
- Provides leadership and formal/informal education to staff and community through in-services, case conferences and group discussions on Hospice philosophy, criteria, medical services and pain/symptom management.
- Consistently represents Signature Hospice with integrity and professionalism to all internal and external customers.
- Actively participates as a member of the IDG and attends IDG meetings, staff meetings, department meetings, in-services, QAPI activities, Safety committee and other related activities as necessary.
- Devotes such time and attention as is necessary to fulfill his/her duties and responsibilities.

The above statements are intended to be a representative summary of the major duties and responsibilities performed by incumbents of this job. The incumbents may be requested to perform job-related tasks other than those stated in this description.

## EDUCATION and EXPERIENCE:

- Current MD/DO in the State of practice without any restriction or subject to any disciplinary or corrective action.
- Certification in hospice and palliative medicine is desirable.

## QUALIFICATIONS and SKILLS:

- Understands hospice and the services provided to patient and family/caregiver.
- Intimate knowledge of Medicare Hospice Benefit.
- Possess a valid driver's license and have an automobile that is insured in accordance with state and/or organization requirements.
- Demonstrates good communication and public relations skills, autonomy, organization, assertiveness, flexibility and cooperation in performing job responsibilities.
- Possess basic computer skills and knowledge of office technology- e.g. email and internet services, facsimile machines, telecommunications devices, etc.
- Can perform the Essential Job Functions/Responsibilities of this job, with or without reasonable accommodations.

# PHYSICAL REQUIREMENTS

1. In an eight (8)-hour workday:

   a. sit 2 hours

   b. stand 4 hours

   c. walk 2 hours

2. Job requires:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. Squatting | ☐ | ☒ | ☐ | ☐ |
| b. Bending | ☐ | ☒ | ☐ | ☐ |
| c. Kneeling | ☐ | ☒ | ☐ | ☐ |
| d. Reaching | ☐ | ☒ | ☐ | ☐ |
| e. Twisting | ☐ | ☒ | ☐ | ☐ |
| f. Crawling | ☒ | ☐ | ☐ | ☐ |
| g. Climbing | ☐ | ☒ | ☐ | ☐ |
| h. Walking on rough ground | ☐ | ☒ | ☐ | ☐ |
| i. Exposure to changes of temperature or humidity | ☐ | ☒ | ☐ | ☐ |
| j. Exposure to dust, fumes, or gases | ☐ | ☒ | ☐ | ☐ |
| k. Being near moving equipment | ☐ | ☒ | ☐ | ☐ |
| l. Working from heights | ☒ | ☐ | ☐ | ☐ |

3. Job requires organization personnel to lift/carry:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. 0–10 lbs | ☐ | ☒ | ☐ | ☐ |
| b. 11–24 lbs | ☐ | ☒ | ☐ | ☐ |
| c. 25–34 lbs | ☐ | ☒ | ☐ | ☐ |
| d. 35–50 lbs | ☒ | ☐ | ☐ | ☐ |

| | | | | |
|---|---|---|---|---|
| e. 51–74 lbs | ☒ | ☐ | ☐ | ☐ |

4. Job requires organization personnel to push/pull:

| | 0% None | 1–33% Occasionally | 34–66% Frequently | 67–100% Continuously |
|---|---|---|---|---|
| a. 0–10 lbs | ☐ | ☒ | ☐ | ☐ |
| b. 11–24 lbs | ☐ | ☒ | ☐ | ☐ |
| c. 25–34 lbs | ☐ | ☒ | ☐ | ☐ |
| d. 35–50 lbs | ☒ | ☐ | ☐ | ☐ |
| e. 51–74 lbs | ☒ | ☐ | ☐ | ☐ |
| f. 75–100 lbs | ☒ | ☐ | ☐ | ☐ |
| g. 100+ lbs (state weight) | ☒ | ☐ | ☐ | ☐ |

5. At work, organization personnel use feet for repetitive movements, i.e., foot controls:

**Right**: ☐ Yes ☐ No **Left**: ☐ Yes ☐ No **Both**: ☒ Yes ☐ No

6. At work, organization personnel use hands for repetitive actions such as:

| | Grasping | Grasping and Turning | Fine Manipulation | Speed Work |
|---|---|---|---|---|
| **Right**: | ☒ Yes ☐ No | ☐ Yes ☒ No | ☐ Yes ☒ No | ☒ Yes ☐ No |
| **Left**: | ☒ Yes ☐ No | ☐ Yes ☒ No | ☐ Yes ☒ No | ☒ Yes ☐ No |

7. Other aspects and demands of the job not listed above:

I have reviewed the above job description and been afforded the opportunity to have my questions answered to my satisfaction.

Employee Signature:_____ Date:_____

## EXHIBIT 22: Recruitment and Retention Information

**Signature Healthcare at Home Recruitment Department and Human Resource Department:**

**Recruitment:**

Signature Healthcare at Home offers a very robust recruitment department. The recruitment department currently employs a Director of Recruiting with over 30 years of experience in recruiting and a three full-time Regional Recruiters, one of which is assigned to Washington State recruiting and other full-time Recruiters servicing other states. Signature Healthcare at Home already has an excellent Home Health Agency in Bellingham, Federal Way, and Bellevue, Washington employing over 120 full-time employees, 16 part-time employees and 29 PRN/On-Call employees. Many of our employees would love a chance to provide Hospice services to patients in their communities. The Washington offices have very low turnover and 98% of Signature employees recommend Signature as a good place to work.

The recruitment department has a very robust recruitment plan to meet all our hiring needs in the area, as well as meet our diversity and veteran's recruitment goals. Signature Healthcare at Home also has many long-term relationships with Universities, Colleges and Educational Institutions in Whatcom, Skagit, Snohomish, Pierce and King County areas to provide clinical internships to variety of students.

Our Recruitment Plan includes but not limited to:

- Online Job Posting
- Career website; application via mobile, tablet or computer
- Sign on Bonuses and Relocation Assistance
- Comprehensive Diversity, Equity and Inclusion Recruitment Strategy
- Multiple sourcing sites; Circaworks.com, Hiretual.com, Linkedin.com and Indeed.com
- Print Media and Direct Mail Recruitment Flyers
- Email Blasts, Text Campaigns and phone calls
- Social Media websites; Facebook, Linkedin.com, Instagram and Glassdoor.com
- Informal Networking
- Employee Referral Program
- Job/Career Fairs
- College/University and Educational Institutions Recruitment
- Trade Publications and Industry Associations
- Radio Advertising
- Staffing Agencies for Temporary Help and or Direct Hires

Signature Healthcare at Home provides a Holistic approach to Hospice care for each patient, which includes an experienced team of a Medical Directors, Physicians, Administrators, Registered Nurses, Licensed Practical Nurses, Certified Nursing Assistants, Social Workers, Bereavement Coordinators, Spiritual Care Coordinators/Chaplains and many hospice volunteers and our After-Hours/Weekend RN Triage Program. Signature Healthcare at Home "Time to Fill" is lower than the national healthcare rate and has a lower turnover than most Healthcare organizations in the area. Signature Healthcare at Home knows that most if not all positions can be filled quickly and timely with qualified candidates to provide

the most comprehensive holistic hospice service that, that the patient deserves and to meet the communities needs. Signature Healthcare at Home does not believe there are any barriers to staffing a Hospice Agency in the State of Washington.

**Onboarding and Human Resources:**

The Recruitment Department is responsible for each new hire:

- Complete online onboarding system for each new hire to complete all new hire documentation almost anywhere by phone, tablet and or laptop
- Signed offer letter, completed references checks, licensure check and OIG check completed
- The onboarding documents are 17 documents to include but not limited to:
    - Copy of Driver's license
    - WA Driving Record Release of Interest Form
    - Verification of Auto Insurance
    - WA Disclosure Authorization
    - Signature PTO Policy
    - Benefit Center
    - Social Media Policy
    - Vehicle Policy
    - Employee Obligations to Secure Patient Information
    - Federal W-4 Form
    - Non-Harassment Policy
    - New Hire Benefit Bundle Notice
    - HIPAA Acceptable Use Policy
    - Employee Standards and Code of Conduct Policy
    - Mileage Reimbursement Policy
    - Emergency Contact Information Form
    - Direct Deposit
    - Confidentiality Statement and Policy
    - CPR Card
- Once all online onboarding paper work has been completed the Human Resource Department will conduct prior to employee starting employment:
    - Completed Background Check
    - Driver's License Check
    - OIG/EPLS/SAM
    - Signed Job Description

The Human Resource Department makes up of a Director of Human Resources, HR Manager, Employee Relations Representative, Benefits/FMLA/ADA Administrator and two full time HR Generalists. This department services all agencies and 810 employees. They work directly with each agency on each new hire.

**Training and Retention:**

Once the new hire reports to work the very first day of employment is spent completed the I-9 From and completing all 8 to 10 Compliance Training modules. Signature Healthcare at Home provides a tablet or Laptop for each employee and HomeCare HomeBase (EMR) online training.

Signature Healthcare at Home has a very extensive Informatics Team and Quality/Compliance Assurance and Improvement Team that provides support to all agencies. Along with the Agency Administrator, RN Director and RN Clinical Managers, Informatics Team and Quality/Compliance Assurance and Improvement Teams, Signature Healthcare at Home provides a comprehensive 30 day new hire training (could be longer depending on employees training needs) that includes; online training, job shadowing and in person training to all new employees to assure that the each new employee can provide the most comprehensive care to our patients and meet all State and Federal rules and regulations and Signature Healthcare at Home policies and procedures.

Signature Healthcare at Home has many retention programs for our employees. From Employee Referral Program Bonus to Higher Education Reimbursement for those employees who would like to continue their education. Signature Healthcare at Home also offers reimbursement for special continuing learning and or certification. Signature Healthcare at Home also offers monthly “Shining Star Awards” to employees who have been recognized by their agencies, peers and co-workers. Our agencies also offer summer BBQ’s, Holiday Parties and Holiday Employee gifts. Our agencies go above and beyond to give back to their communities to food drives, delivering food, fund raising and toy drives to name a few.

Signature Healthcare at Home provides a comprehensive benefit package to include but not limited to; Medical (three different plans to choose from), Dental, Vision, Prescription Coverage, Flexible Spending Account (FSA), 401K Plan, Employee Assistance Programs (EAP), Telehealth Program, Life Insurance, Disability Insurance, Voluntary Benefits and a generous Paid Time off program which offers full time employees up to 4 weeks of PTO per year and 6 paid holidays.

Signature Healthcare at Home creates an atmosphere where you can learn and grow with in our organization. As the picture states there is upward mobility and growth from almost any position. Our organization offers an Administrator in Training program and many nurses have been promoted to Quality Assurance Registered Nurses to Clinical Managers.


Apply online at Signature-Careers.com

**EXHIBIT 23: Trella Health Pierce County Marketshare Data**

## Market Share in Pierce County by Home Health Agency

| Home Health Agency | NPI | Patient Location | Recent Four Quarters | 2020 Q2 | 2020 Q1 | 2019 Q4 | 2019 Q3 | 2019 Q2 | 2019 Q1 | 2018 Q4 | 2018 Q3 | % Change Admits | Market Share Change |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| KINDRED AT HOME | 1801825187 | Pierce WA | 31.09% | 25.89% | 30.47% | 32.11% | 33.67% | 35.03% | 32.43% | 31.16% | 31.02% | -14.3% | -1.37% |
| MULTICARE GOOD SAMARITAN HOME HEALTH | 1275647133 | Pierce WA | 17.91% | 19.71% | 18.67% | 16.94% | 17.08% | 14.25% | 14.80% | 13.09% | 17.74% | 7.3% | 2.98% |
| PUGET SOUND HOME HEALTH | 1912242678 | Pierce WA | 13.74% | 14.85% | 12.35% | 14.42% | 13.80% | 13.72% | 15.66% | 16.00% | 16.50% | -20.4% | -1.70% |
| CHI FRANCISCAN HEALTH AT HOME | 1972919249 | Pierce WA | 10.68% | 10.81% | 10.84% | 10.61% | 10.52% | 9.23% | 11.12% | 13.43% | 10.66% | -13.9% | -0.41% |
| ASSURED HOME HEALTH | 1770998528 | Pierce WA | 6.36% | 7.24% | 7.82% | 5.71% | 5.05% | 6.00% | 5.53% | 7.55% | 5.84% | -8.5% | 0.14% |
| SIGNATURE HEALTHCARE AT HOME | 1598716136 | Pierce WA | 5.37% | 4.87% | 4.80% | 5.51% | 6.08% | 6.13% | 6.05% | 6.93% | 5.84% | -23.0% | -0.87% |
| ENVISION HOME HEALTH | 1881023026 | Pierce WA | 3.92% | 3.92% | 3.91% | 4.29% | 3.55% | 4.55% | 3.29% | 3.67% | 2.26% | 1.0% | 0.45% |
| KINDRED AT HOME | 1992734271 | Pierce WA | 1.24% | ins | 0.96% | 1.36% | 1.64% | 1.25% | 1.45% | 1.11% | 1.39% | -14.5% | -0.06% |
| WESLEY HOMES COMMUNITY HEALTH SERVICES | 1740312479 | Pierce WA | 0.97% | ins | 0.96% | 0.82% | 1.02% | 0.99% | 1.05% | 0.76% | 1.24% | -13.6% | -0.03% |
| PROVIDENCE SOUNDHOMECARE AND HOSPICE | 1063415198 | Pierce WA | 0.84% | 1.31% | 0.82% | 0.82% | ins | ins | ins | ins | ins | 83.3% | 0.43% |
| KAISER FOUNDATION HEALTH PLAN OF WASHINGTON | 1528198660 | Pierce WA | 0.71% | ins | 0.96% | ins | ins | 0.79% | ins | - | ins | 54.2% | 0.30% |
| CAREAGE HOME HEALTH | 1215436431 | Pierce WA | 0.65% | ins | ins | 0.75% | ins | - | - | - | - | ins | |
| EVERGREENHEALTH HOME CARE | 1588662761 | Pierce WA | 0.55% | ins | ins | ins | 0.82% | ins | ins | ins | ins | 3.6% | 0.08% |
| ASSURED HOME HEALTH & HOSPICE | 1154397305 | Pierce WA | 0.40% | ins | ins | ins | ins | ins | ins | ins | ins | -34.4% | -0.15% |
| BROOKDALE HOME HEALTH | 1316337298 | Pierce WA | 0.36% | ins | ins | ins | ins | ins | ins | ins | ins | 46.2% | 0.14% |
| KINDRED AT HOME* | 1114958725 | Pierce WA | 0.21% | - | 0.08% | 0.09% | 0.08% | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| COMMUNITY HOME HEALTH AND HOSPICE* | 1871573766 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | - | 0.12% | 0.11% | - | 0.14% | - | |
| PROVIDENCE HOME SERVICES* | 1063524346 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | 0.08% | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| RELIANCE HOME HEALTH CARE, INC.* | 1881019545 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| NORTON HOME HEALTH* | 1871940841 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| CARETENDERS* | 1992958250 | Pierce WA | 0.03% | - | - | 0.09% | - | 0.12% | 0.11% | - | - | | |
| BAYADA HOME HEALTH CARE, INC.* | 1043581846 | Pierce WA | 0.03% | - | - | - | 0.08% | 0.12% | - | - | - | | |
| ANGELS CARE HOME HEALTH* | 1982609160 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| ACHH OF CA - REDDING* | 1992751382 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| FRONTIER HOME HEALTH AND HOSPICE* | 1053563171 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| VNSW* | 1053311092 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | 0.12% | - | | |
| BAYHEALTH INC.* | 1851520621 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| SUNCREST HOME HEALTH SERVICES, INC.* | 1861634115 | Pierce WA | 0.03% | 0.13% | - | 0.09% | - | 0.12% | 0.11% | - | - | | |
| KC'S HOME HEALTH CARE* | 1871048025 | Pierce WA | 0.03% | - | 0.08% | - | - | 0.12% | - | - | - | | |
| SIGNATURE HEALTHCARE AT HOME* | 1871526236 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| ENCOMPASS HEALTH HOME HEALTH* | 1962854331 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | - | - | - | - | - | | |
| HONORHEALTH HOME HEALTH* | 1972562460 | Pierce WA | 0.03% | 0.13% | - | - | - | - | 0.11% | - | - | | |
| HOME CARE SOUTHWEST* | 1285720896 | Pierce WA | 0.03% | 0.13% | - | - | - | 0.12% | - | - | - | | |
| SIGNATURE COASTAL, LLC* | 1831653989 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | - | | |
| BANNER HOME CARE ARIZONA* | 1023051927 | Pierce WA | 0.03% | - | 0.08% | 0.09% | 0.08% | - | 0.11% | 0.12% | 0.14% | - | |
| CVH HOME HEALTH SERVICES* | 1083797880 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| BAYADA HOME HEALTH CARE, INC.* | 1942569702 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | - | 0.14% | - | |
| COLUMBIA RIVER HOME HEALTH* | 1699263079 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | 0.12% | 0.11% | - | - | | |
| EVERGREEN HOME HEALTHCARE* | 1497991418 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| MESA VIEW HOME CARE, LLC* | 1811174196 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| HORIZON HOME HEALTH AND HOSPICE* | 1689996357 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| PARTNERS HEALTHCARE AT HOME - HOME CARE* | 1083644017 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| PARTNERS IN HOME CARE, INC.* | 1629135447 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| SPECIALTY HOME HEALTH CARE, INC* | 1154324838 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| CAREAGE HOME HEALTH LLC* | 1629288618 | Pierce WA | 0.03% | 0.13% | - | 0.09% | 0.08% | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| AHC HOME HEALTH OF ARIZONA, LLC* | 1508051434 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | - | - | | |
| AMEDISYS HOME HEALTH* | 1154307924 | Pierce WA | 0.03% | 0.13% | - | - | - | 0.12% | 0.11% | - | - | | |
| TRI CITIES HOME HEALTH* | 1679547244 | Pierce WA | 0.03% | - | - | 0.09% | 0.08% | 0.12% | - | 0.12% | 0.14% | - | |
| DESERT HOME HEALTH SERVICES, INC.* | 1740287697 | Pierce WA | 0.03% | 0.13% | 0.08% | - | 0.08% | - | - | - | - | | |
| KINDRED AT HOME* | 1205867819 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | 0.12% | - | - | 0.14% | - | |
| ALASKAN HOME HEALTH, INC* | 1336540624 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| SAINT FRANCIS HOSPITAL, INC.* | 1538634076 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| APPLIED HEALTHCARE SOLUTIONS, INC.* | 1487070645 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| PROVIDENCE VNA HOME HEALTH* | 1215189808 | Pierce WA | 0.03% | - | 0.08% | - | 0.08% | 0.12% | - | 0.12% | 0.14% | - | |
| CATER 2 YOU HOME HEALTH CARE* | 1821395351 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| SIGNATURE HOME HEALTH-WATERFORD* | 1780772996 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| KINDRED AT HOME* | 1831129162 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| PALOMAR HEALTH HOME HEALTH SERVICES* | 1205806676 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| KLINE GALLAND HOME HEALTH* | 1548513252 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| YAMHILL VALLEY HOME HEALTH* | 1255730743 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| ENCOMPASS HEALTH HOME HEALTH* | 1598218281 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| BAYADA HOME HEALTH CARE, INC.* | 1215352869 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| LIGHTHOUSE HOME HEALTH CARE, INC.* | 1215297478 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| PROHEALTH HOME CARE, INC* | 1215375175 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| SUMMA HEALTH AT HOME* | 1013422534 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| VISITING HEALTH SERVICES* | 1205804101 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | 0.12% | - | | |
| NORTH STAR HEALTHCARE* | 1649475948 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| SANROSE HOME HEALTH SERVICES,INC.* | 1780888206 | Pierce WA | 0.03% | - | 0.08% | - | - | 0.12% | - | - | - | | |
| AVIDITY HOME HEALTH* | 1659675106 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| CHOICE HOME HEALTH CARE* | 1558392209 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| SOUTHWEST FLORIDA HOME CARE INC* | 1609803931 | Pierce WA | 0.03% | - | - | 0.09% | - | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| SACRED HEART HOME HEALTH* | 1275524498 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| PINNACLE HOME CARE* | 1689600082 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| PROFESSIONAL HOME CARE SERVICE* | 1073732590 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| DFW HOME HEALTH* | 1619237310 | Pierce WA | 0.03% | - | - | - | 0.08% | - | 0.11% | 0.12% | - | | |
| AMEDISYS HOME HEALTH OF COVINGTON* | 1134177835 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| BLIZE HEALTHCARE* | 1558667485 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| THE ULTIMATE HOME CARE, INC* | 1407804016 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| ST. BERNARDINE CARE PROVIDERS,INC.* | 1831246032 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| THERACARE HOME HEALTH* | 1497235352 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| ALARS HOME HEALTH, LLC* | 1073809919 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| KINDRED AT HOME* | 1265789820 | Pierce WA | 0.03% | - | 0.08% | - | 0.08% | - | - | - | - | | |
| ARKANSAS HOMECARE OF FORREST CITY, LLC* | 1609821982 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| ALPHA HOME HEALTH* | 1518482215 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | 0.11% | - | - | | |
| ENLOE MEDICAL CENTER* | 1376626903 | Pierce WA | 0.03% | - | - | 0.09% | - | 0.12% | - | - | - | | |
| EXCELL HOME CARE, INC.* | 1588630081 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| NATIONAL HOME HEALTH SERVICES, INCORPORATED* | 1104067826 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| ENCOMPASS HEALTH HOME HEALTH* | 1770561268 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| ENCOMPASS HEALTH HOME HEALTH* | 1518351865 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| MISSION HOME HEALTH OF SAN DIEGO, LLC* | 1063726628 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | - | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| PROV HOSPICE & H C OF SNOHOMISH CTY* | 1174856892 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | 0.08% | 0.12% | 0.11% | 0.12% | 0.14% | - | |
| NURSE ON CALL* | 1891747952 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | 0.12% | - | - | 0.14% | - | |
| GOOD LIFE HOME CARE* | 1235370107 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| LORIAN HEALTH* | 1578882833 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| COUNTY OF FLATHEAD* | 1093817371 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| KARE-IN-HOME HEALTH SERVICES, INC.* | 1174527030 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| VISITING NURSE ASSOCIATION OF INDIAN RIVER COUNTY, INC.* | 1306843768 | Pierce WA | 0.03% | - | - | 0.09% | 0.08% | - | - | - | - | | |
| VISITING NURSE ASSOCIATION OF THE INLAND COUNTIES* | 1174525380 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | 0.14% | - | |
| ADVENTIST HEALTH HOMECARE SERVICES* | 1174954689 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| HEALTHY LIVING AT HOME - REDDING, LLC.* | 1063853398 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | 0.14% | - | |
| VA RESIDENTIAL HEALTHCARE SERVICES, LLC* | 1588053482 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| HOME HEALTH AGENCY - ARIZONA LLC* | 1245224096 | Pierce WA | 0.03% | 0.13% | - | 0.09% | - | - | - | - | - | | |
| EDEN HOME HEALTH* | 1316031230 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | 0.08% | 0.12% | - | - | 0.14% | - | |
| WELL CARE HOME HEALTH, INC* | 1760470660 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | | |
| ENCOMPASS HEALTH HOME HEALTH* | 1093760639 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| VERITAS HOME HEALTH* | 1578523726 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | | |
| RECOVER HEALTH* | 1306072939 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | | |
| ADVANCED HOME HEALTH NW OF WENATCHEE* | 1366962953 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | - | | |
| EXCELLENCE HOME HEALTHCARE* | 1003070590 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |
| AFS HOME HEALTH, LLC* | 1447574512 | Pierce WA | 0.03% | - | - | 0.09% | - | 0.12% | - | - | - | | |
| ADVANCED HOME HEALTH AND HOSPICE* | 1366686826 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | | |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DIVINE CARE HOME HEALTH SERVICES INC.* | 1063616563 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| ENCOMPASS HEALTH HOME HEALTH* | 1174770515 | Pierce WA | 0.03% | - | - | 0.09% | 0.08% | - | - | - | - | - |
| ADVENTIST HEALTH HOME CARE OF LAKE COUNTY* | 1063762896 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| NAMASTE HOME HEALTH* | 1003197344 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| OLYMPIC MEDICAL HOME HEALTH* | 1437259165 | Pierce WA | 0.03% | 0.13% | 0.08% | - | 0.08% | 0.12% | 0.11% | - | - | - |
| VALLEY HOME CARE, LLC* | 1508895715 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | 0.12% | - | - |
| FIRST CHOICE HOME HEALTH & HOSPICE* | 1952305286 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| NIGHTINGALE HOMECARE* | 1366543449 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| MOUNTAINVIEW HOME HEALTH, LLC* | 1578583399 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | - | - | - |
| RX STAFFING AND HOME CARE* | 1003026220 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| KINDRED AT HOME* | 1437185139 | Pierce WA | 0.03% | - | 0.08% | - | - | 0.12% | - | 0.12% | - | - |
| JOHN MUIR HOME HEALTH SERVICES* | 1437161452 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| PATIENT CARE PROFESSIONALS INC* | 1295728616 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| HORIZONS HOME CARE INC.* | 1508298639 | Pierce WA | 0.03% | - | - | - | 0.08% | - | 0.11% | - | - | - |
| LIFE WELLNESS HOME HEALTH AGENCY, LLC* | 1093027757 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| CENTRAL WASHINGTON HEALTH SERVICES ASSOCIATION* | 1699888024 | Pierce WA | 0.03% | 0.13% | 0.08% | - | - | - | - | 0.12% | 0.14% | - |
| HARBORS HOME HEALTH & HOSPICE* | 1699777276 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | 0.08% | 0.12% | 0.11% | - | - | - |
| FIRSTAT NURSING SERVICES* | 1407996267 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| TEAMSELECT HOME CARE OF COLORADO, LLC* | 1346564127 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| LIFE CARE PLUS INC* | 1134287303 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| PROVIDENCE HOME HEALTH* | 1790873461 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | 0.12% | - | - |
| HEALTHY LIVING AT HOME - PALM DESERT, LLC.* | 1265848683 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | 0.12% | - | - |
| ASSISTED HEALTHCARE SERVICES* | 1487743225 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| THEMA HEALTH SERVICES* | 1477547123 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| ARIZONA HOME CARE LLC* | 1568433969 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | 0.12% | - | - |
| ENCOMPASS HEALTH HOME HEALTH* | 1346481710 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| DELTACARE HOME HEALTH SERVICES LLC* | 1356352033 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| BUTTE HOME HEALTH INC.* | 1568492700 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| GOLDEN HOME HEALTH NEVADA* | 1568726867 | Pierce WA | 0.03% | - | - | - | 0.08% | 0.12% | - | 0.12% | - | - |
| BAYADA HOME HEALTH CARE* | 1225478605 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| HOME HEALTH AND HOSPICE CARE, INC.* | 1750337366 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| CAPITOL HOME HEALTH* | 1225472913 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| YAKIMA REGIONAL HOME HEALTH* | 1801888920 | Pierce WA | 0.03% | - | 0.08% | - | - | 0.12% | - | - | - | - |
| VALLEY REGIONAL HOME HEALTH, INC.* | 1275975138 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| ACACIA HOME HEALTH, INC* | 1679977979 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| LIVINGSTON HEALTH CARE* | 1689641284 | Pierce WA | 0.03% | 0.13% | - | 0.09% | - | - | - | - | - | - |
| ADVENT HOME HEALTH* | 1689882557 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| CONCIERGE HOME CARE* | 1942238506 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| MARQUARDT HOME HEALTH* | 1629071121 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| SANTE HOME HEALTH* | 1629217278 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | - | - | - |
| ATRIO HOME HEALTH* | 1710931308 | Pierce WA | 0.03% | - | 0.08% | - | - | 0.12% | - | 0.12% | - | - |
| WEL-HOME HEALTH MILES CITY* | 1528040904 | Pierce WA | 0.03% | - | - | - | 0.08% | 0.12% | - | - | - | - |
| VISITING NURSE SERVICE OF NEW YORK HOME CARE* | 1528059805 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | - | - |
| EDEN HOME HEALTH* | 1003356403 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| TEXAS HOME HEALTH GROUP OF TEMPLE, LLC* | 1184154536 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| HUMAN TOUCH HOME HEALTH CARE AGENCY, INC.* | 1528153244 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| EMERALD HEALTHCARE, INC.* | 1710410964 | Pierce WA | 0.03% | 0.13% | 0.08% | 0.09% | 0.08% | 0.12% | 0.11% | 0.12% | 0.14% | - |
| HOME HEALTH CARE OF FLORIDA* | 1003194697 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| KINDRED AT HOME* | 1538198817 | Pierce WA | 0.03% | - | - | 0.09% | - | - | 0.11% | - | 0.14% | - |
| SYMBII HOME HEALTH* | 1184914772 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| SEA CREST HOME HEALTH* | 1538347646 | Pierce WA | 0.03% | 0.13% | - | - | - | 0.12% | - | - | - | - |
| TEXAS HOME HEALTH SKILLED SERVICES* | 1720506785 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| KINDRED AT HOME* | 1184653461 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| ACHH ROGUE VALLEY, LLC* | 1912228727 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| BEECH HOME CARE & MEDICAL, INC.* | 1376782987 | Pierce WA | 0.03% | - | 0.08% | - | - | - | 0.11% | - | - | - |
| SUN-TRIUNE HEALTHCARE, INC.* | 1124006051 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| HEALTHY LIVING AT HOME - VANCOUVER, LLC* | 1255812020 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| CARING TOUCH HOME CARE LLC* | 1316255334 | Pierce WA | 0.03% | 0.13% | - | - | - | - | 0.11% | - | - | - |
| SUMMITWEST CARE* | 1326047614 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| ENCOMPASS HOME HEALTH OF FLORIDA* | 1649664996 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| PROVIDENCE HEALTH & SERVICES - WASHINGTON* | 1558512368 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | 0.14% | - |
| DOCTOR'S CHOICE HOME CARE INC* | 1205051497 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| KINDRED AT HOME* | 1770933798 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| AMERICAN HOME HEALTH SERVICES, INC* | 1114279536 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| DOYLESTOWN HOSPITAL VISITING NURSE/HOME CARE DEPARTMENT | 1073579900 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |
| GRACE HOME HEALTH NURSING SERVICES* | 1245435957 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | - | - |
| SIGNATURE HOME HEALTH* | 1649368853 | Pierce WA | 0.03% | 0.13% | - | - | 0.08% | 0.12% | - | 0.12% | - | - |
| DEACONESS HOMECARE* | 1326039470 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| ARIAS HOME HEALTH* | 1538508791 | Pierce WA | 0.03% | - | - | 0.09% | 0.08% | - | - | - | - | - |
| ANGELS CARE HOME HEALTH OF DODGE CITY* | 1649720012 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| ATLANTIC HOME HEALTH CARE, LLC* | 1003976705 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| FIRST CHOICE HOME HEALTH & HOSPICE* | 1124036249 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| BENDER'S HOME CARE, INC.* | 1184826877 | Pierce WA | 0.03% | - | - | 0.09% | - | - | - | - | - | - |
| SONORA REGIONAL HOME HELATH* | 1548251507 | Pierce WA | 0.03% | - | 0.08% | 0.09% | - | - | - | - | - | - |
| WEST FLORIDA HEALTH HOME CARE NORTH TAMPA* | 1124085238 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| ENVISION HOME HEALTH & HOSPICE* | 1386793123 | Pierce WA | 0.03% | - | 0.08% | - | - | - | - | - | - | - |
| OPTIMAL CARE, INC.* | 1588697841 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| CENTRAL COAST HOME HEALTH INC* | 1609044924 | Pierce WA | 0.03% | 0.13% | - | - | - | - | - | - | - | - |
| ALLINA HEALTH HOME HEALTH* | 1316985039 | Pierce WA | 0.03% | - | - | - | 0.08% | - | - | - | - | - |

## EXHIBIT 24: Hospice Quality Information & Internal Plans of Correction

Signature Hospice Quality Care Compare: Hospice Synopsis

- **Any condition level citations for any agency in the most recent survey**

No Condition Level deficiencies on any of the most recent hospice surveys.

- **Any items on Care Compare: Hospice care Quality Measures ≥ 0.5% below National Average and what we are doing to correct**

*Care Compare: Hospice care Current Collection period: January 1, 2019 through December 31, 2019.*

| **Agency** | **Item below State and National Average** |
|---|---|
| Payette, Idaho | Family caregiver experience<br>- Communication with family<br>- Getting timely help<br>- Help for pain and symptoms<br>- Training family to care for patient<br>- Rating of this hospice<br>- Willing to recommend this hospice<br>Quality of patient care<br>- Patients who got an assessment of all 7 HIS quality measures at the beginning of hospice care to meet the HIS Comprehensive Assessment Measure requirements<br>- Patients or caregivers who were asked about their beliefs and values at the beginning of hospice care<br>- Patients who were checked for pain at the beginning of hospice care<br>- Patients who were checked for shortness of breath at the beginning of hospice care<br>- Patients who got timely treatment for shortness of breath |
| Salt Lake City, Utah | Family caregiver experience<br>- Communication with family<br>- Getting timely help<br>- Treating patient with respect<br>- Emotional and spiritual support<br>- Training family to care for patient<br>Quality of patient care<br>- Patients who were checked for shortness of breath at the beginning of hospice care |
| Portland, Oregon | Family caregiver experience<br>- Communication with Family |

| | |
|---|---|
| | - Getting timely help<br>- Help for pain and symptoms<br>- Training family to care for patient<br>- Rating of this hospice<br>- Willing to recommend this hospice<br>Quality of patient care<br>- Patients or caregivers who were asked about their beliefs and values at the beginning of hospice care |
| Medford, Oregon | Family caregiver experience<br>- Communication with Family<br>- Getting timely help<br>- Treating patient with respect<br>- Emotional and spiritual support<br>- Help for pain and symptoms<br>- Training family to care for patient<br>- Rating of this hospice<br>- Willing to recommend this hospice<br>Quality of patient care<br>- Patients who got an assessment of all 7 HIS quality measures at the beginning of hospice care to meet the HIS Comprehensive Assessment Measure requirements<br>- Patients or caregivers who were asked about treatment preferences like hospitalization and resuscitation at the beginning of hospice care<br>- Patients who were checked for pain at the beginning of hospice care<br>- Percentage of patient getting at least one visit from a registered nurse, a physician, a nurse practitioner, or a physician assistant in the last 3 days of life |

**Corrective Activities**:

- Signature has contracted with SHP to look at real-time data as part of our corrective plan to monitor quality measures monthly in order to make changes prior to the data being publicly reported on Care Compare.

- Signature has developed Corporate Level Strategic Initiatives. These are:
    - HQRP Measure: Comprehensive Assessment at Admission – Composite Process Measure
        - On Care Compare, Signature HCH average score is 85.5% which is below the National average of 88.7%
        - On SHP, Signature HCH average score is 86.48% demonstrating an upward trend

  - CAHPS Survey Data: Recommend Hospice
    - On Care Compare, Signature average score is 83.5% which is slightly below the National average of 84%
    - On Pinnacle, Signature average score is 83.8% which is an upward trend
    - Made a switch to a new survey vendor
    - Noting trends for monthly, quarterly, and annual survey responses

- Agency QAPI teams meet monthly to review real-time SHP HQRP measures and CAHPS survey data to develop specific plans and interventions to address any areas with low trends

- Agency reporting Quality data to the Corporate QAPI Manager. Corporate QAPI Manager educates on trended company-wide findings and assists with individualized agency specific quality education as requested

- Trainings provided to clinical staff at the agency level no less than quarterly including trended CAHPS and HQRP measures where there is opportunity for improvement

- Patient satisfaction surveys reviewed at the agency level no less than monthly during QAPI meetings

OIG Audit:
Northwest Hospice Portland location which includes branches in Salem and Eugene (PTAN 38-1553) was subject to a random OIG audit in September 2018. We received our draft letter of findings in January 2020 which indicated that 19 of the 100 claims did not comply with eligibility requirements for Medicare Hospice services.
After review of these 19 claims by an experienced physician certified in Hospice and Palliative Care our plan is to file a statement of non-concurrence with all 19 claims.

## EXHIBIT 25: Home Health Quality Information & Internal Plans of Correction

Signature Home Health Quality and Home Health Compare Synopsis

- **Any condition level citations for any agency in the most recent survey**

No condition-level deficiencies on the most recent surveys for any of the 3 WA home health agencies or other Signature HH agencies.
- Plans of correction written and accepted for all G-tag deficiencies
- Chart audits totaling 10% of average patient census conducted quarterly at the Corporate and Agency levels to ensure compliance with Federal and State regulations. Offices continue to demonstrate compliance

- **Any items on HH Compare that are below State and National Average and what we are doing to correct** *(Signature is contracted with SHP to look at real-time data)*

| **Agency** | **Item below State and National Average** |
|---|---|
| Bellevue | - Improvement in Ambulation and Moving Around<br>- Improvement in Bed Transfers<br>- Improvement in Bathing<br>- Hospital Readmission after Home Health Discharge (*better than National median, but slightly higher rate than State median)*<br>- New or Worsened Pressure Ulcer<br>- Timely Initiation of Care<br>- Improvement in Taking Medications by Mouth |
| Bellingham | - Likelihood to Recommend Home Health Agency<br>- Hospital Readmission after Home Health Discharge<br>- Improvement in Taking Medications by Mouth<br>- Improvement in Bed Transfers |
| Federal Way | - Likelihood to Recommend Home Health Agency<br>- Hospital Readmission after Home Health Discharge |
| Portland/Salem | - Likelihood to Recommend Home Health Agency<br>- Timely Initiation of Care |
| Eugene/Albany | - Likelihood to Recommend Home Health Agency<br>- Improvement in Bed Transfers<br>- Improvement in Dyspnea<br>- Wound Improvement or Healing After Operation |

| | |
|---|---|
| | - Timely Initiation of Care<br>- Emergency Room Visit Without Hospital Admission |
| Medford | - Flu vaccine<br>- Pneumococcal Vaccine<br>- Hospital Admission<br>- Emergency Room Visit without Hospital Admission<br>- Likelihood to Recommend Home Health Agency |
| Newport/Oregon Coast | - Wound Improved or Healed After Operation<br>- Timely Initiation of Care<br>- Assessed for Risk of Falling<br>- Flu Shot<br>- Emergency Room Visit without Hospital Admission |
| Salt Lake City | - Improvement in Ambulation and Moving Around<br>- Improvement in Bed Transfers<br>- Improvement in Dyspnea<br>- Assessed for Depression<br>- Emergency Room Visit without Hospital Admission<br>- Likelihood to Recommend Home Health Agency |

**Corrective Activities**:

- Agency invested in comprehensive OASIS training for all clinical staff who conduct OASIS SOC and ROC assessments to ensure accuracy of OASIS item scoring

- Agency invested in OASIS certification training and testing for all Clinical Managers to ensure accuracy of OASIS item scoring and to provide follow up training to clinical staff

- Agency QAPI teams meet monthly to review real-time SHP Quality Item measures, develop specific plans and interventions to address with focus on patient satisfaction

- Trainings provided to clinical staff at the agency level no less than quarterly including scoring specific OASIS items, discharge planning to reduce rehospitalization risk

- Corporate QAPI Manager established quarterly meetings with office leadership to review Internal Plans of Correction and provide feedback on trends, planned interventions, and measurable goals

- QAPI Coordinator position created for WA and OR offices and filled to assist offices with identification of improvement areas, targeted interventions, SMART goal development,

common factor analysis (60-day hospitalizations, patients not improving from SOC/ROC to discharge in Quality item areas)

- Patient satisfaction surveys reviewed at the agency level no less than monthly during QAPI meetings

- QA RN position created and filled for the Bellevue and Federal Way offices to review OASIS assessments and care plans (including discharge planning), suggest changes, and provide 1:1 training with staff identified as having knowledge deficits in OASIS item scoring, care plan development, and/or discharge planning

- QA RN position created and filled for the Portland, Salem, and Albany offices to review OASIS assessments and care plans (including discharge planning), suggest changes, and provide 1:1 training with staff identified as having knowledge deficits in OASIS item scoring, care plan development, and/or discharge planning

**Footnote Sources:**

1. 2019 National Healthcare Quality and Disparities Report: https://www.ahrq.gov/research/findings/nhqrdr/nhqdr19/index.html

Agency for Healthcare Research and Quality

# 2019 National Healthcare Quality and Disparities Report

For the 17th year in a row, AHRQ is reporting on healthcare quality and disparities. The annual National Healthcare Quality and Disparities Report is mandated by Congress to provide a comprehensive overview of the quality of healthcare received by the general U.S. population and disparities in care experienced by different racial and socioeconomic groups. The report is produced with the help of an Interagency Work Group led by AHRQ.

## Introduction

The *National Healthcare Quality and Disparities Report* assesses the performance of our healthcare system and identifies areas of strengths and weaknesses, as well as disparities, for access to healthcare and quality of healthcare. Quality is described in terms of six priorities: patient safety, person-centered care, care coordination, effective treatment, healthy living, and care affordability. The report is based on more than 250 measures of quality and disparities covering a broad array of healthcare services and settings.

## Report Files

AHRQ no longer offers print copies of the report, but the files are set up for two-sided color printing and may be downloaded free of charge. If you have questions about printing or copying, contact Doreen Bonnett at 301-427-1899 or doreen.bonnett@ahrq.hhs.gov.

- Introduction and Methods (PDF, 1 MB)
- Executive Summary (Powerpoint, 2.5 MB) (PDF, 950 KB)
- Report and Appendixes A and B (PDF, 3.9 MB)
  - Appendix A. Data Sources Used for 2019 Report
  - Appendix B. Definitions and Abbreviations Used in 2019 Report
- Quality Trends data tables (PDF, 848 KB)
- Disparities data tables (PDF, 2.9 MB)
- Data Sources (PDF, 433 KB)
- Measure Specifications (PDF, 4 MB)
- Additional Methods Information:
  - Methods Applying AHRQ Quality Indicators to Healthcare Cost and Utilization Project (HCUP) Data for the 2019 National Healthcare Quality and Disparities Report
  - Detailed Methods for the Medical Expenditure Panel Survey (PDF, 194 KB)

## Related Data and Tools

- Quality and Disparities Report Data and Tools
- Data Query (search data across specific measures)

*Page last reviewed January 2021*
*Page originally created December 2020*

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2. Indian Health Disparities. (2019, October). Retrieved from https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf

Indian Health Service

# Indian Health Disparities

Members of 573 federally recognized American Indian and Alaska Native Tribes and their descendants are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that provides a comprehensive health service delivery system for approximately 2.56 million of the nation's estimated 5.2 million American Indians and Alaska Natives. The IHS strives for maximum tribal involvement in meeting the health needs of its service population, who live mainly on or near reservations and in rural communities, mostly in the western United States and Alaska.

The American Indian and Alaska Native people have long experienced lower health status when compared with other Americans. Lower life expectancy and the disproportionate disease burden exist perhaps because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Diseases of the heart, malignant neoplasm, unintentional injuries, and diabetes are leading causes of American Indian and Alaska Native deaths (2009-2011).

American Indians and Alaska Natives born today have a life expectancy that is 5.5 years less than the U.S. all races population (73.0 years to 78.5 years, respectively).

American Indians and Alaska Natives continue to die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.

Given the higher health status enjoyed by most Americans, the lingering health disparities of American Indians and Alaska Natives are troubling. In trying to account for the disparities, health care experts, policymakers, and tribal leaders are looking at many factors that impact upon the health of Indian people, including the adequacy of funding for the Indian health care delivery system.

***Additional information on the IHS is available at***
***https://www.ihs.gov and https://www.ihs.gov/aboutihs***

# MORTALITY DISPARITY RATES

American Indians and Alaska Natives (AI/AN) in the IHS Service Area

2009-2011 and U.S. All Races 2010
(Age-adjusted mortality rates per 100,000 population)

| | AI/AN Rate 2009-2011 | U.S. All Races Rate – 2010 | Ratio: AI/AN to U.S. All Races |
|---|---|---|---|
| **ALL CAUSES*** | 999.1 | 747.0 | 1.3 |
| Diseases of the heart (heart disease) | 194.1 | 179.1 | 1.1 |
| Malignant neoplasm (cancer) | 178.4 | 172.8 | 1.0 |
| Accidents (unintentional injuries)* | 93.7 | 38.0 | 2.5 |
| Diabetes mellitus (diabetes) | 66.0 | 20.8 | 3.2 |
| Alcohol-induced | 50.5 | 7.6 | 6.6 |
| Chronic lower respiratory diseases | 46.6 | 42.2 | 1.1 |
| Cerebrovascular disease (stroke) | 43.6 | 39.1 | 1.1 |
| Chronic liver disease and cirrhosis | 42.9 | 9.4 | 4.6 |
| Influenza and pneumonia | 26.6 | 15.1 | 1.8 |
| Drug-induced | 23.4 | 12.9 | 1.8 |
| Nephritis, nephrotic syndrome (kidney disease) | 22.4 | 15.3 | 1.5 |
| Intentional self-harm (suicide) | 20.4 | 12.1 | 1.7 |
| Alzheimer's disease | 18.3 | 25.1 | 0.7 |
| Septicemia | 17.3 | 10.6 | 1.6 |
| Assault (homicide) | 11.4 | 5.4 | 2.1 |
| Essential hypertension diseases | 9.0 | 8.0 | 1.1 |

* Unintentional injuries include motor vehicle crashes.

N*OTE: Rates are adjusted to compensate for misreporting of American Indian and Alaska Native race on state death certificates. American Indian and Alaska Native age-adjusted death rate columns present data for the 3-year period specified. U.S. All Races columns present data for a one-year period. Rates are based on American Indian and Alaska Native alone; 2010 census with bridged-race categories.*

*October 2019*

3. Veterans Affairs: https://www.va.gov/vetdata/veteran_population.asp

# VetPop2018: A Brief Description

The Department of Veterans Affairs (VA) completed a new Veteran Population Projection Model, VetPop2018, which is planned for public release in May 2020. The model will be used by the Office of Enterprise Integration (OEI) as well as other VA offices for strategic, long-term planning and to understand demographic characteristics of Veteran population. This paper summarizes the design, data sources and results of the new model. Details of all aspects of the development and content of the model are available from the Analytics Service in the Office of Data Governance and Analytics in OEI. Extensive documentation is being prepared and is expected to be available by August 2020.

VetPop2018 is the latest in a series of Veteran Population Projection Models that provide data widely used both inside and outside VA as the official estimate and projection of the total number of Veterans and their demographic characteristics. The new model maintains the general approach from the prior model, VetPop2016, and incorporates more recent survey data from the American Community Survey (ACS) (U.S. Census Bureau 2018) and administrative data from VA and the Department of Defense (DoD).[1]

## What's New

- The model incorporates more recent survey data, 2018 ACS, in the baseline population estimation and projection of additional characteristics of race, ethnicity, and period of service.
- The VetPop2018 estimate of the starting population is about 700,000 higher than the VetPop2016 projection, mainly due to additional Veterans identified in USVETS, the integrated database of VA and DoD administrative information.
- The model incorporates more recent administrative data on actual separations through 9/30/2018, that are identified in USVETS 2018.
- Migration assumptions are updated using state-level migration data from USVETS reflecting more recent migration trends.
- An adjusted ratio method is used to allocate state level projections to counties, as was done for VetPop2007 and earlier models.

## Methodology

VetPop2018 is a deterministic population projection model that estimates and projects the living and deceased Veteran population at the end of each Federal Fiscal Year (FY) from 2018 to 2048. Using the best available Veteran data at the end of FY2018 as the base population, living and deceased Veteran counts are projected by key demographic characteristics such as age and gender at various geographic levels for the next 30 years.

[1] See the Major Data Sources section for a description of these and other sources.

VetPop2018 estimates the starting population count at the baseline date, 9/30/2018, and projects 1 year at a time by accounting for mortality, migration and separation assumptions. The first task of baseline estimation involves selecting the qualifying records from USVETS to ensure only those with valid identity and active duty service, other than training, are included. To supplement for limitations in the USVETS administrative data, ACS estimates of Veteran population are blended with the USVETS extract summary. The blended data serve as the estimated living Veteran population at the end of FY2018. The Veteran population counts so obtained represent the end of subsequent FYs are then adjusted by subtracting deaths, applying net-migration assumptions and then adding new military separations. Iteratively, the Veteran population is projected for each subsequent fiscal year to obtain projections for 30 fiscal years. Each year's projections are at the national and state levels by the core demographics of age and gender. Additional characteristics including race, ethnicity, period of service, officer status, and branch of service are projected by allocating the respective national or state projections. Race, ethnicity, and period of service projections are available at national and state levels. Officer status and branch of service projections are available at the national level.

For each projected year, the state level projections by age and gender are allocated to counties using general population trends obtained from Woods & Poole Economics (W&P) (Woods&Poole Economics 2018). We also account for impacts of military base installations and foreign-born population in each county.

## Key Assumptions

Mortality assumptions are based on Veteran mortality information from USVETS and U.S. general population mortality data from the *2019 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds* (2019 OASDI Trustees Report) (Board of Trustees 2019) which is produced by the Social Security Administration (SSA). Mortality projections are developed by single year of age and gender by blending the mortality rates between VA and SSA. The blended mortality rates are then smoothed and projected for the next 30 years using implied mortality improvement factors from the 2019 OASDI Trustees Report.

Migration assumptions are developed using Veteran migration information from USVETS. We analyzed the migration data for fiscal years 2005 through 2017 (migration years 2005-2006 through 2016-2017) to obtain 5-year weighted moving averages starting with migration year 2012-2013. Given the relatively small amount of migration, net migration at the state level by age group and gender is modeled for VetPop2018. Previously in VetPop2016, net migration at the county level by age group and gender was used. However, that assumption was based on Internal Revenue Service (IRS) data for an older time frame, 2000 to 2009, and access to IRS data is not available for our model update. Another possible source of migration data is ACS, but to represent all counties, a broader time frame of 5-year ACS data would need to be used in addition to other survey related issues, such as small sample size, high variability, and respondent-reported Veteran status. For these reasons, the VetPop2018 migration assumption is developed from USVETS.

Separation assumptions account for future military separations from the U.S. Armed Forces. Projected separations by the DoD's Office of the Actuary for the military services (Army, Air Force, Navy, and Marine Corps) are used as the main driver of future separations and are assumed to reflect projected changes in future military strength by fiscal year. For separations from non-DoD agencies (Coast Guards, National Oceanic and Atmospheric Administration, and U.S. Public Health Service) and federally activated National Guards and Reserves, historic information in USVETS is used in estimation.

For county-level projections, the change in ratio of Veterans to the general population in the projection years relative to the ratio at baseline date is the same for both the county level and the state level. Also, counties with higher percentages of Armed Forces personnel or lower percentages of foreign-born may have more Veterans than other counties.

## Major Data Sources

The U.S. Veterans Eligibility Trends and Statistics (USVETS) database, also produced by the Analytics Service in the Office of Data Governance and Analytics, is a collection of datasets made from the integration of Veteran information from the benefits and services administered by VA with military separations data from the Department of Defense to support department-wide analyses on the Veteran population. Although much of the Veteran population is represented by the two data sources, information on some Veterans who have not had a relationship with VA and who served only prior to 1970, is not complete.[2] This limitation may explain the higher estimates by the ACS of Veterans at older ages. Another limitation is related to geography. For the Veterans included in the integrated data, information on their residence may not be available or current as not all Veterans are required to report or update such information with VA.

GORGO projections (Department of Defense Office of the Actuary 2017) from the DoD's Office of the Actuary are the main source of data for projecting future Veterans. They include projected separations by age, officer status, length of service, and type of separation from active military duty for each projection year.

The American Community Survey is an ongoing annual survey by the Bureau of the Census conducted in every county across the nation, including every municipality in Puerto Rico. As the largest nationally representative survey in U.S. with a sample of about 3 million households each year, the ACS collects essentially the same detailed demographic, social, economic, and housing information previously collected every ten years on the decennial Census long-form questionnaire. In VetPop models, ACS has been used as a benchmark and incorporated into baseline estimations in a way that recognizes differences between survey data and administrative records. In ACS, Veteran status is self-, or proxy reported while administrative records contain empirical indicators of Veteran status. Also, due to a 2-month residence rule in ACS, the survey universe is different than administrative records, with an undercount of people who are highly mobile. Finally, the ACS has a smaller sample size and thus ACS estimates can

[2] In 1973, historic information was destroyed in a fire at the National Personnel Records Center. https://www.archives.gov/personnel-records-center/fire-1973

have high variability, particularly for less populated areas. Despite these differences, the ACS is a high-quality benchmark for Veteran data.

## Selected Results

VetPop2018 estimates 20.3 million living Veterans at the baseline of 9/30/2018, which is about 3.7% higher than the corresponding VetPop2016 projection. The estimate is higher because with the 2018 version of USVETS approximately 1 million additional persons were determined to be very likely Veterans. This change has also affected the comparison with ACS. The VetPop2016 estimate of baseline population was 1.8 million higher than the 2015 ACS 1-year estimate. For the release of VetPop2018, it is about 2.3 million higher than the 2018 ACS 1-year estimate.

Over the next 30 years, the total Veteran population is projected to steadily decrease (-1.7%) while the women Veteran population is projected to increase slightly (+0.3%). In comparison, VetPop2016 had projected steady decline (-1.8%) for total Veteran population and a slight increase (+0.6%) for women Veterans.

At the state level, revised migration estimates resulted in minimal changes in the projected state distribution.  For example, in FY2045, the difference in state percent distribution between VetPop2018 and VetPop2016 is almost 0 percentage points for 46 states. The difference is -1 percentage point for 2 states and 1 percentage point for 4 states. The difference in out-years is more noticeable at the county level since VetPop2018 uses state-level migration estimates and general population projections. For future VetPop model updates, we are pursuing county-level migration data through the U.S. Census Bureau to revisit the approach of more direct projection at the county level.

## Conclusion

VetPop2018 is the 9$^{th}$ generation of the Veteran Population Projection Model with improvements in data and model update process. The main data source of USVETS continues to improve in terms of data quality and increased coverage of the Veteran population.

For questions on the VetPop2018 model, please contact the Analytics Service via e-mail at VANCVAS@VA.GOV.

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Signature Hospice Pierce, LLC

**Table 9L: VetPop2018 County-Level Veteran Population by STATE, AGE GROUP, GENDER, 2018-2048**

| | |
|---|---|
| State | Washington |
| Age Group | (All) |
| Gender | (All) |

*Numbers from this table should be reported to the nearest 1,000.*

| Veterans | | Date | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FIPS | County, St | 9/30/2018 | 9/30/2019 | 9/30/2020 | 9/30/2021 | 9/30/2022 | 9/30/2023 | 9/30/2024 | 9/30/2025 | 9/30/2026 | 9/30/2027 | 9/30/2028 | 9/30/2029 | 9/30/2030 | 9/30/2031 | 9/30/2032 | 9/30/2033 | 9/30/2034 | 9/30/2035 | 9/30/2036 | 9/30/2037 | 9/30/2038 | 9/30/2039 | 9/30/2040 | 9/30/2041 | 9/30/2042 | 9/30/2043 | 9/30/2044 | 9/30/2045 | 9/30/2046 | 9/30/2047 | 9/30/2048 |
| 53053 | Pierce,WA | 94,481 | 93,350 | 92,149 | 90,809 | 89,515 | 88,319 | 87,259 | 86,141 | 85,049 | 83,915 | 82,832 | 81,785 | 80,766 | 79,771 | 78,730 | 77,803 | 76,883 | 75,986 | 75,144 | 74,339 | 73,571 | 72,867 | 72,200 | 71,552 | 70,923 | 70,338 | 69,804 | 69,287 | 68,784 | 68,313 | 67,860 |
| **Grand Total** | | **94,481** | **93,350** | **92,149** | **90,809** | **89,515** | **88,319** | **87,259** | **86,141** | **85,049** | **83,915** | **82,832** | **81,785** | **80,766** | **79,771** | **78,730** | **77,803** | **76,883** | **75,986** | **75,144** | **74,339** | **73,571** | **72,867** | **72,200** | **71,552** | **70,923** | **70,338** | **69,804** | **69,287** | **68,784** | **68,313** | **67,860** |

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# Increasing Veterans' Hospice Use: The Veterans Health Administration's Focus On Improving End-Of-Life Care

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**ABSTRACT In 2009 the Department of Veterans Affairs (VA) began a major, four-year investment in improving the quality of end-of-life care. The Comprehensive End of Life Care Initiative increased the numbers of VA medical center inpatient hospice units and palliative care staff members as well as the amount of palliative care training, quality monitoring, and community outreach. We divided male veterans ages sixty-six and older into categories based on their use of the VA and Medicare and examined whether the increases in their rates of hospice use in the last year of life differed from the concurrent increase among similar nonveterans enrolled in Medicare. After adjusting for age, race and ethnicity, diagnoses, nursing home use in the last year of life, census region, and urbanicity of a person's last residence, we found a 6.9–7.9-percentage-point increase in hospice use over time for the veteran categories, compared to a 5.6-percentage-point increase for nonveterans (the relative increases were 20–42 percent and 16 percent, respectively). The VA's substantial investment in palliative care appears to have resulted in greater hospice use by older male veterans enrolled in the VA, a critical step forward in caring for veterans with serious illnesses.**

Improving end-of-life care is a continuing goal of the Department of Veterans Affairs (VA) through the Veterans Health Administration (VHA), the largest integrated health care system in the United States. The VHA provides care in outpatient clinics, community living centers (nursing homes), home-based settings, and VA medical centers (hospitals).[1] It also pays for care provided in the community when needed care is not available within its networks. In 2002 the VA began the establishment of a systemwide hospice and palliative care program. The mission of this program was to "honor Veterans' preferences for care at the end of life."[2(p2)] A key goal was to increase dying veterans' enrollment in hospice, since hospice is associated with higher quality of care and care that is more aligned with patients' and families' preferences.[3,4]

Reaching this goal required a three-pronged strategic approach, addressing the three pathways to veterans' receipt of hospice care: care provided by the VA, care purchased by the VA in community hospices, and care paid for by Medicare in non-VA facilities. For veterans using the VA health care system, the hospice and palliative care program endorsed the concurrent use of hospice and disease-modifying care. This concurrent care approach honors veterans' preferences and promotes hospice enrollment for those unwilling to forgo disease-modifying care in order to receive hospice care (as essentially required to receive the Medicare hospice benefit). The VA program also mandated that in every

VA hospital there be palliative care teams, inpatient palliative care consultation programs, and education about palliative care for leaders and staff members.[5] Additionally, since veterans are eligible to receive community hospice care outside of VA facilities—paid for either by Medicare (if the veteran is eligible for Medicare) or by the VA, based on the veteran's preference—the VA implemented a national program of Hospice-Veteran Partnerships and a "We Honor Veterans" program.[5]

Improvements in end-of-life care were observed after the implementation of the hospice and palliative care program.[6] However, since there was no dedicated additional funding accompanying the program mandates, there were concerns about the adequacy of its staffing: Staff members often had collateral duties, and access to inpatient hospice and palliative care was not reliably available at all VA medical centers. Therefore, in fiscal year 2009 the VA implemented its Comprehensive End of Life Care (CELC) Initiative.[2] This four-year initiative included funding for 1.5 full-time-equivalent staff at all VA medical centers to be dedicated to palliative care consulting; the creation of the Veteran Experience Center (formerly the Performance Reporting and Outcomes Measurement to Improve the Standard of care at End-of-life [PROMISE] Center), whose mission was to develop and monitor outcomes and quality indicators of VA care; training programs for leaders and staff members and ongoing mentoring of palliative care teams to develop and enhance their expertise in hospice and palliative care; and inpatient infrastructure for such care, which included staffing for inpatient hospice and palliative care units. Fifty-four new hospice and palliative care inpatient units were established by FY 2012, for a total of 113 units collectively containing 1,138 beds.[2] Additionally, the "We Honor Veterans" program was expanded.[7]

By FY 2011, 44 percent of all VA inpatient deaths were in hospice beds (compared to 30 percent in FY 2008), and the use of VA-purchased hospice care had begun to grow.[2] By FY 2012, 71 percent of veterans dying with cancer used hospice.[8] However, it was unknown whether the observed increases were greater than the substantial increases observed among Medicare beneficiaries.[9] Nor was it known whether increases in hospice use were the same for veterans with differing use of health care from the VA, Medicare, or both.

Our evaluation study focused on male decedents ages sixty-six and older. We used population-based data on veterans enrolled in VA health care (subsequently referred to as enrolled veterans) and data on people from the 5 percent Medicare sample of fee-for-service Medicare beneficiaries who were not also enrolled in VA health care (subsequently referred to as nonveterans) to evaluate whether the VA's CELC Initiative resulted in significantly greater use of hospice for enrolled veterans who died after implementation of the initiative (FY 2010–14), compared to use before implementation (FY 2007–08). We also evaluated whether categories of enrolled veterans with differing use of VA and Medicare had significantly greater increases in hospice use over time, compared to nonveterans. This evaluation allowed us to determine whether the substantial VA investment in palliative care through the initiative led to increased use of hospice for older male enrolled veterans.

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## Study Data And Methods

This study used enrollment and utilization data from the VA and Medicare to identify decedents and define the cohort and study variables. The study was based on enrolled male veterans[10] who died in FY 2007–14 and who were at least sixty-six years old at the time of death, and on similar decedents in the 5 percent sample of Medicare beneficiaries (excluding those enrolled in the VA). It was conducted as an evaluation study requested and paid for by the VA Office of Geriatrics and Extended Care.

**POPULATION AND STUDY COHORTS** The difference-in-differences analysis evaluated a total of 1,270,969 decedents—1,129,803 enrolled veterans and 141,166 nonveterans from the 5 percent Medicare sample files. The decedents were males who died in FY 2007–08 or FY 2010–14 and resided in one of the fifty states or the District of Columbia. We also excluded decedents who had been enrolled in Medicare Advantage at any time during their last year of life and Medicare enrollees with no use of Medicare or VA health care in their last year of life. In our descriptive longitudinal analysis, we also examined people who died in FY 2009—153,897 enrolled veterans and 19,867 nonveterans, for FY 2007–14 totals of 1,283,770 and 161,033, respectively. Females were not evaluated since they represent a very small proportion of enrolled veterans and accounted for only approximately 2 percent of older enrolled veterans who died in VA inpatient beds between July 2008 and June 2011.[11]

For both analyses, we first determined whether enrolled veterans were also enrolled in fee-for-service Medicare. Then we determined whether enrolled veterans' use of health care in the last year of life (exclusive of hospice use) included care reimbursed by Medicare or the VA (that is, provided or purchased by the VA). Based on these data, we identified four categories of en-

rolled veterans: VA users, dual enrollees—that is, enrolled in both Medicare and the VA (our difference-in-differences analysis included 58,291 veterans in this category); Medicare users, dual enrollees (426,023); dual users, dual enrollees (635,527); and VA users and enrollees (9,962). The fifth group comprised Medicare users and enrollees (99,058).

**HOSPICE MEASUREMENT AND COVARIATES** We measured whether any hospice was received in the last year of life. VA-provided hospice was identified using the Medical Statistical Analysis System (SAS) inpatient acute, observational, and extended care files and the Medical SAS outpatient encounter file. VA-purchased hospice was identified using the Medical SAS fee-basis files. Medicare claims were used to identify Medicare hospice.

The difference-in differences analyses controlled for age, race and ethnicity, diagnoses, nursing home use in the last year of life, census region, and urbanicity of last residence. Age at death was categorized as ages 66–74, 75–84, and 85 and older. Race/ethnicity was categorized as white, African American, Hispanic, and other race or unknown. Documented diagnoses in the last year of life were categorized as other researchers have done,[9] using *International Classification of Diseases*, Ninth Revision (ICD-9), classification codes for cancer, chronic obstructive pulmonary disease, debility, failure to thrive, heart or circulatory conditions, neurological conditions, and other conditions. An indicator variable for any nursing home use in the last three months of life was included, since hospice use differs for people in nursing homes, compared to people in the community.[9] Also, the use of a VA community living center exposes patients to hospice beds and hospice and palliative care staff.

To control for geographic differences in available services and health care cultures, we assigned each decedent to one of the nine census regions based on his state of residence. Also, we collapsed Census Bureau urban-rural groups into five categories of urbanicity and assigned these categories to decedents using the ZIP code of last residence.

**ANALYSES** To test the impact of the CELC Initiative on hospice use, we conducted a difference-in-differences analysis in which we compared decedent groups who died after the initiative was implemented (FY 2010–14) to those who died before implementation (FY 2007–08). Using multivariate Poisson regression with robust standard errors, we compared enrolled veterans in each of the four categories listed above to nonveterans (the reference group). In the difference-in-differences analysis, we used a term for the interaction between each of four categories of veterans and an indicator variable for the post period to test whether the adjusted increase of hospice use by the category in the post period (compared to the pre period) was more or less than the increase we observed for nonveterans. We also performed a model specification sensitivity analysis by running two parallel models: a Poisson model with the same specification but with fixed effects for the 139 VA medical center health care regions, and changing the Poisson specification to a logistic regression.

**The VA's strategic efforts to improve the quality of end-of-life care have been effective.**

To derive population-based estimates of the impact of the CELC Initiative, we compared adjusted (predicted) marginal incidence risk ratios of hospice use in the post period for each of the four categories of veterans and the nonveterans to each group's hospice use in the pre period. The estimation was performed using Stata, version 14.

We also conducted a sensitivity analysis, in which we estimated the same model for only those decedents who had an acute inpatient stay in the last year of life. We did this to compare whether the effect of the CELC Initiative was greater for decedents with such a stay than for the population of decedents with and without inpatient stays. This analysis included decedents with more exposure to the health care system—which for enrolled veterans meant exposure to the setting where most VA investment in hospice and palliative care occurred.

**LIMITATIONS** Our methods had limitations as well as advantages. First, although we used population-based VA and Medicare administrative data for enrolled veterans and nonveterans in the 5 percent Medicare sample who died in the study period, the range of sociodemographic and clinical variables available in these data is limited. Thus, we were unable to control for potentially important unmeasured differences between veterans and nonveterans, such as socioeconomic status, patients' preferences, and caregiver support. However, our use of a pre-post difference-in-differences design that compared

similar types of enrollees and users over time addresses this concern to some extent.

Second, the CELC Initiative included numerous strategic efforts, and we could not determine which specific effort or efforts might be associated with the changes we observed. However, our use of four categories of enrolled veterans allowed us to identify when the observed change might be related to VA inpatient or community-based efforts, and our sensitivity analysis provided insight into the impact of VA investments in medical centers. Nonetheless, our group of nonveteran decedents included veterans not enrolled in the VA's health care system, estimated to be 58–67 percent of all veterans.[10] Given that it is unlikely the VA's community-based outreach efforts would differentially affect these veterans, we may have underestimated the impact of community outreach.

Last, our findings are not necessarily generalizable to older female decedents. However, since females account for a small proportion of older enrolled veteran decedents and, compared to male enrolled veterans, have higher hospice use and higher reported quality of care,[11] our exclusion of females is unlikely to have affected the validity of our findings and conclusions. Online Appendix Exhibit A1 provides additional details about this evaluation study's design and analyses.[12]

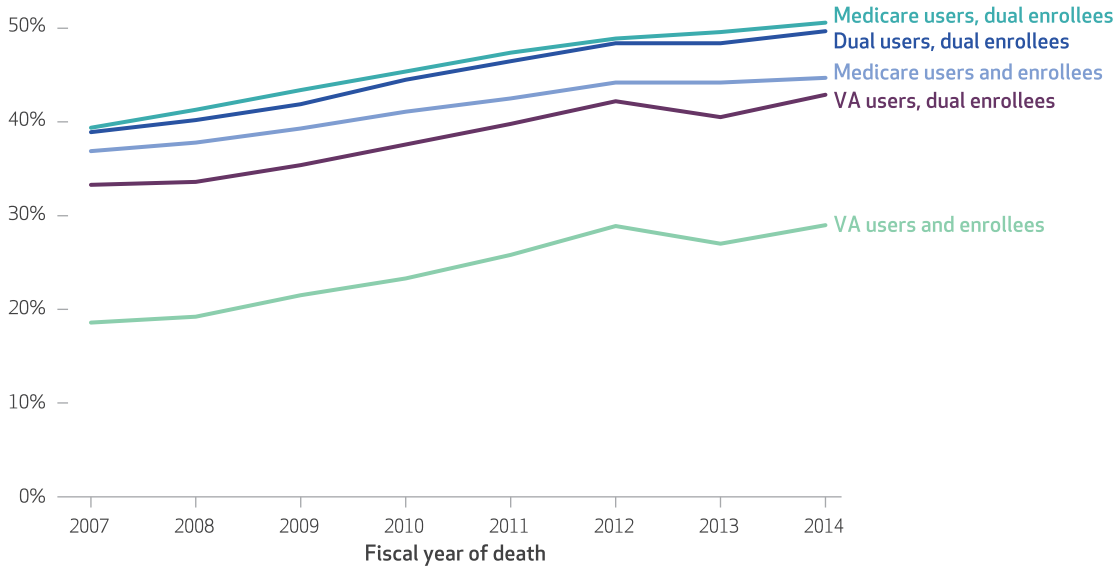
## Study Results

**LONGITUDINAL RATES OF HOSPICE USE** Generally, we found a trend of increasing hospice use after FY 2008 (Exhibit 1). Historically, the two categories of veterans who used only VA health care had lower rates of hospice use than nonveterans did, but hospice use by the two categories of veterans increased more sharply than nonveterans' hospice use. The two categories of veterans who were dual enrollees and who used Medicare alone or both Medicare and the VA also showed increases in hospice use over time that were greater than that for nonveterans. Of note, and likely the result of unresolved data issues, the two categories of veterans who used only the VA showed a decrease in hospice use in FY 2013. However, in FY 2014 their use returned to approximately the same rates as in FY 2012.

**PRE-POST CHARACTERISTICS OF THE STUDY POPULATION** Online Appendix Exhibit A2 shows characteristics of enrolled veterans and nonveterans by whether they died in the pre or post period.[12] In both time periods, nonveterans and enrolled veterans with any Medicare use (that is, users of Medicare alone or in conjunction with the VA) were older than decedents who used only the VA. Also, those who used only the VA were more likely to be African American: In FY 2010–14, 14 percent of VA users who were dually enrolled and 19 percent of VA users enrolled only

**EXHIBIT 1**

**Unadjusted annual percentages of patients enrolled in the VA, fee-for-service Medicare, or both who used hospice care in fiscal years 2007–14, by year of death**




**SOURCE** Authors' analysis of data from the following sources: (1) Department of Veterans Affairs (VA) files on patients enrolled in the VA: the Vital Status File; Assistant Deputy Under Secretary for Health's enrollment file; and inpatient, outpatient, and fee-basis (VA-purchased care) files. (2) The 5 percent Medicare sample files for patients not enrolled in the VA but enrolled in Medicare. **NOTES** "Dual" means both VA and Medicare. All patients except "Medicare users and enrollees" are VA-enrolled veterans.

in the VA were African American, compared to 6–8 percent for other study groups (Appendix Exhibit A2).[12]

Compared to other groups, enrolled veterans with any Medicare use generally had a greater prevalence of chronic diseases (such as chronic obstructive pulmonary disease, heart or circulatory conditions, and neurological conditions). In both the pre and post periods, they also had greater use of nursing homes and—similar to nonveterans—greater prevalence of neurological conditions (including Alzheimer disease and other dementias). In contrast, veterans who used only the VA had substantially lower proportions of heart or circulatory conditions, neurological conditions, and nursing home use (Appendix Exhibit A2).[12]

**EFFECT OF THE INITIATIVE ON HOSPICE USE** Rates of hospice use increased in the years after implementation of the CELC Initiative for all of our study groups. However, for the four categories of enrolled veterans, the increases were 6.9–7.9 percentage points (relative increases of 20–42 percent), while for nonveterans, it was 5.6 percentage points (a relative increase of 16 percent) (Exhibit 2). For all categories of veterans, percentage-point increases were significantly greater than for nonveterans. These results were robust when we used a Poisson model with fixed effects for the 139 VA medical center regions, as well as when we used a logistic regression model (Appendix Exhibit A3).[12]

Appendix Exhibit A4[12] shows unadjusted hospice enrollment rates by decedent characteristics. For each group of decedents enrolled in Medicare, compared to the group's overall pre-post increase in hospice use, we found lower increases for those ages 66–74 and greater increases for those ages 85 and older, with neurologic conditions, and with nursing home use in the last year of life. In particular, hospice use among veterans enrolled in Medicare and with VA nursing home use in the last year of life increased by 16 percentage points (Appendix Exhibit A4).[12] This increase is compatible with the fact that almost all VA hospice beds are in VA medical center–based community living centers (nursing homes), which means that veterans in community living centers are in close proximity to hospice and palliative care staff and beds.

**SENSITIVITY ANALYSES** Much of the CELC Initiative's financial investment was in the inpatient setting (that is, in inpatient hospice and palliative care teams and consultations, training for leaders and staff members, quality oversight, and new hospice units and beds in medical centers). We therefore expected that if the initiative drove any observed significant population-level changes, we would see even greater effects for veterans exposed to a VA hospital (as inpatients). We tested this expectation by conducting similar analyses of only those decedents who had any hospital care in the last year of life.

This subpopulation had somewhat different unadjusted rates of hospice use during the study period. For the two categories of veterans who used only the VA and for nonveterans, the rates of hospice use in FY 2007 were substantially higher when we examined only those who were hospitalized in the last year of life (Exhibit 3),

**EXHIBIT 2**

**Estimated effects of the VA Comprehensive End of Life Care (CELC) Initiative on adjusted rates of hospice use**

| | Deaths in the pre period (FY 2007–08) | Deaths in the post period (FY 2010–14) | Difference between periods (percentage points) | Difference between veterans and nonveterans in change between periods (percentage points) |
|---|---|---|---|---|
| **NONVETERANS** | | | | |
| Medicare users and enrollees | 35.9% | 41.5% | 5.6 | —[a] |
| **VETERANS** | | | | |
| Medicare users, dual enrollees | 38.8 | 46.7 | 7.9 | 2.3** |
| Dual users, dual enrollees | 37.9 | 45.5 | 7.6 | 2.0** |
| VA users, dual enrollees | 32.2 | 39.1 | 6.9 | 1.3**** |
| VA users and enrollees | 18.2 | 25.8 | 7.6 | 2.0**** |

**SOURCE** Authors' analysis of data from the following sources: (1) Department of Veterans Affairs (VA) files on patients enrolled in the VA: the Vital Status File; Assistant Deputy Under Secretary for Health's Enrollment File; and Medical SAS inpatient acute, observational, extended care, outpatient encounter, and fee-basis (VA-purchased care) files. (2) 5 percent Medicare sample files for patients enrolled in Medicare and not the VA. **NOTES** The four-year CELC Initiative was implemented in fiscal year 2009. "Dual" means both VA and Medicare. Models controlled for patient age groups, diagnoses in the last year of life, race/ethnicity, nursing home and hospital use in the last year of life, census region, and urban-rural categories (explained in the text). Poisson multivariate regression with robust standard errors was used. To convey population-based estimates, we report adjusted (predicted) marginal incidence rates to show the pre-post differences for each group and to compare veterans and nonveterans. All differences are absolute differences. [a]Not applicable. **$p < 0.05$ ****$p < 0.001$

compared to the whole sample (Exhibit 1). Also, a trend of accelerated hospice use beginning in FY 2009, when the CELC Initiative was implemented, is more evident in Exhibit 3 than in Exhibit 1. Furthermore, by FY 2014 only veterans not enrolled in Medicare who used the VA had lower use of hospice than nonveterans—while in Exhibit 1 two veteran subpopulations had lower hospice use.

The two categories of veterans who used only the VA (exclusive of any hospice use) had substantially greater percentage-point changes in hospice use between the pre and post periods (9.7 percentage points and 10.1 percentage points) (Exhibit 4), compared to the whole sample (6.9 percentage points and 7.6 percentage points) (Exhibit 2). Also, compared to the pre-post increase observed for nonveterans, enrolled veterans in these categories had an approximately 4-percentage-point greater increase in hospice use (3.9 percentage points and 4.3 percentage points) (Exhibit 4). This is more than double the adjusted difference we found in the whole sample (1.3 percentage points and 2.0 percentage points) (Exhibit 2). Of interest, among VA users who were dual enrollees and used hospice, the proportion who used VA-provided hospice increased by 6 percentage points—from 43 percent in the pre period to 49 percent in the post period (Appendix Exhibit A5).[12]

Last, the findings for the two categories of veterans who used Medicare were similar in this sensitivity analysis to the results from our analysis of the whole sample (Exhibits 2 and 4). However, it is important to note that for enrolled veterans who used both Medicare and the VA, only 27 percent received hospital care in the VA (data not shown). This fact may account to some extent for the similar findings.

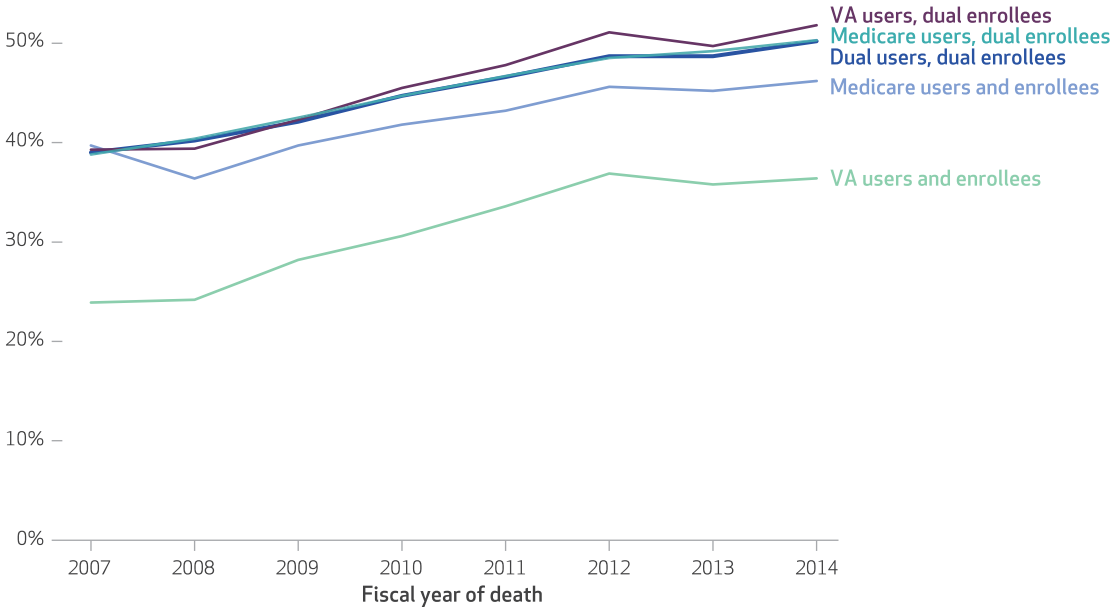
This sensitivity analysis arguably presents a more valid VA–non-VA comparison, given that by design we included in both the nonveteran and enrolled veteran groups decedents who were more engaged in their respective health care systems (because they were hospitalized in the last year of life). Still, while veterans enrolled in the VA and using only it increased their unadjusted hospice use by 50 percent during the study period (from 24 percent in FY 2007 to 36 percent in FY 2014) (Exhibit 3), their use in the end of the period was still below the 46 percent for nonveterans (even though this rate reflected only a 16 percent relative increase).

## Discussion

Our findings suggest that the VA's strategic efforts to improve the quality of end-of-life care,

**EXHIBIT 3**

**Unadjusted annual percentages of patients enrolled in the VA, fee-for-service Medicare, or both who used hospice care in fiscal years 2007–14 and who were hospitalized in the last year of life, by year of death**




**SOURCE** Authors' analysis of data from the following sources: (1) Department of Veterans Affairs (VA) files on patients enrolled in the VA: the Vital Status File; Assistant Deputy Under Secretary for Health's enrollment file; and inpatient, outpatient, and fee-basis (VA-purchased care) files. (2) The 5 percent Medicare sample files for patients not enrolled in the VA but enrolled in Medicare. **NOTES** "Dual" means both VA and Medicare. All patients except "Medicare users and enrollees" are VA-enrolled veterans.

**EXHIBIT 4**

**Estimated effects of the VA Comprehensive End of Life Care (CELC) Initiative on adjusted rates of hospice use for patients who were hospitalized in the last year of life**

| | Deaths in the pre period (FY 2007–08) | Deaths in the post period (FY 2010–14) | Difference between periods (percentage points) | Difference between veterans and nonveterans in change between periods (percentage points) |
|---|---|---|---|---|
| **NONVETERANS** | | | | |
| Medicare users and enrollees | 37.0% | 42.9% | 5.8 | —[a] |
| **VETERANS** | | | | |
| Medicare users, dual enrollees | 38.4 | 46.5 | 8.2 | 2.4*** |
| Dual users, dual enrollees | 38.3 | 46.2 | 7.8 | 2.0*** |
| VA users, dual enrollees | 37.9 | 47.6 | 9.7 | 3.9**** |
| VA users and enrollees | 23.3 | 33.5 | 10.1 | 4.3**** |

**SOURCE** Authors' analysis of data from the following sources: (1) Department of Veterans Affairs (VA) files on patients enrolled in the VA: the Vital Status File; Assistant Deputy Under Secretary for Health's Enrollment File; Medical SAS inpatient acute, observational, extended care, outpatient encounter and fee-basis (VA-purchased care) files. (2) 5 percent Medicare sample files for patients enrolled in Medicare and not the VA. **NOTES** The four-year CELC Initiative was implemented in fiscal year 2009. "Dual" means both VA and Medicare. Models controlled for patient age groups, diagnoses in last year of life, race/ethnicity, nursing home use in the last year of life, census region, and five urban-rural categories (explained in the text). Poisson multivariate regression with robust standard errors was used. To convey population-based estimates, we report adjusted (predicted) marginal incidence rates to show the pre-post differences for each group and to compare veterans to nonveterans. All differences are absolute differences. FY is fiscal year. [a]Not applicable. ***$p < 0.01$ ****$p < 0.001$

as reflected by increased hospice use, have been effective. Specifically, we found that hospice use by older male veterans enrolled in and using the VA increased shortly after the Comprehensive End of Life Care Initiative began and that their adjusted pre-post rate increase surpassed that of nonveterans. The finding that the category of veterans arguably the most dependent on the VA (those enrolled only in the VA and using its facilities) had the greatest differential increase in hospice use between the pre and post periods (compared to nonveterans in Medicare) strengthens the validity of our findings. Furthermore, given that the preponderance of the CELC Initiative's investment occurred in VA medical centers, findings from the sensitivity analysis showing that VA users and enrollees with hospital exposure had even greater differential pre-post increases in hospice use (compared to nonveterans) provide further support for the validity of our findings.

The CELC Initiative investments central to our findings for enrolled veterans with any use of the VA are likely those that occurred in VA medical centers and their community living centers.[2] Also, while the concurrent use of hospice and disease-modifying care was endorsed by the VA in 2002, the hospice and palliative care staff increases associated with the implementation of the CELC Initiative likely led to its increased receipt. In fact, between 2006 and 2012 for cancer decedents with any VA-provided cancer treatment, the use of palliative care consultations increased from 23 percent to 53 percent, hospice use increased from 55 percent to 68 percent, and the use of concurrent care increased from 16 percent to 25 percent.[13]

Additionally, among enrolled veterans who used only the VA (exclusive of any hospice use), higher proportions used VA-provided hospice care (in hospice beds in community living centers) after the implementation of the CELC Initiative, and this increase was more pronounced for those with any hospital use in the last year of life (Appendix Exhibits A5 and A6).[13] Other health care systems have observed similar increases in hospice use, as well as improvements in quality and reductions in costs, with the introduction of concurrent care and upstream palliative care.[14]

Many enrolled veterans obtaining care from the VA are also referred to non-VA hospice providers. In fact, over 50 percent of enrolled veterans in all of our four categories and during both the pre and post periods received hospice care from community providers (either Medicare hospice or care purchased by the VA), and the use of VA-purchased hospice care increased between the two periods for all veterans with any VA use (Appendix Exhibits A5 and A6).[13] In relation to the increase in use of VA-purchased hospice care and in addition to any effect of concurrent care, it is likely that increases both in the availability of palliative care consultations and in clinical staff members' palliative care knowledge associated with the implementation of the CELC Initiative have led to greater recognition of the need for hospice care and thus to referrals to

**The VA continues to build upon the improvements achieved and to address remaining issues.**

non-VA providers. Intervention research within VA medical centers found that staff training improved end-of-life care practices.[15]

Enrolled veteran decedents who were not enrolled in Medicare and used VA hospital care in the last year of life had a 50 percent increase in unadjusted hospice use (from 24 percent in FY 2007 to 36 percent in FY 2014), compared to a 16 percent increase for nonveteran Medicare decedents (from 40 percent to 46 percent). Nevertheless, this group of enrolled veterans had the lowest use of hospice in FY 2014. This category of veterans accounted for only approximately 1 percent of the older male enrolled veterans who died in the study period.

While veterans who were only enrolled in the VA were similar in many respects to VA users who were dual enrollees, among all of the sample groups, the group enrolled only in the VA included the highest proportion of African Americans (19 percent). Also, based on their ineligibility for Medicare and their VA priority group status, many had low incomes, were likely to have been unemployed, or both. Veterans with service-connected disabilities of 50 percent or more and those deemed unemployable by the VA because of service-connected conditions are in priority group 1. Veterans who are catastrophically disabled are in priority group 4, and those in priority group 5 generally have low incomes. Of the VA users who were enrolled only in the VA, 36 percent were in priority group 1, and 47 percent were in priority groups 4 and 5 (higher proportions than was the case with any other category of enrolled veterans). Thus, lower hospice use by VA users who were enrolled only in the VA is not unexpected, given that minority Medicare beneficiaries and those with lower incomes have been shown to have lower rates of hospice use.[16] Even though the CELC Initiative had a large impact on hospice use, additional focused efforts are likely needed to achieve more equitable access to hospice for this category of enrolled veterans.

Nonetheless, thousands of seriously ill veterans have gained increased access to hospice and palliative care since the implementation of the VA's hospice and palliative care program in 2002.[2] In this evaluation, we estimated the additional impact of the CELC Initiative on enrolled veterans' use of hospice. Given that 819,418 male enrolled veterans died in FY 2010–14 (Appendix Exhibit A2)[12] and the adjusted differential percentage-point increases in hospice use between the pre and post period, our results indicate that 17,046 additional enrolled veterans who died in the post period received hospice because of the differential increase we found to be associated with the CELC Initiative. The overwhelming majority of these veterans received nonhospice care from Medicare in their last year of life, as either dual users or Medicare-only users (data not shown).

Thus, while the biggest differential pre-post increases in hospice use (compared to nonveterans) were for veterans with only VA enrollment and use and with any hospital use in the last year of life, the VA's strategic efforts beyond the VA inpatient setting also appear to have been critical in increasing hospice access for the large population of enrolled veterans who use Medicare. In fact, efforts that occurred after implementation of the CELC Initiative resulted in more than 3,000 community hospices making commitments to improve their care of veterans at the end of life.[7]

Given the above and considering the countless studies documenting that dying people receive higher-quality end-of-life care when they receive hospice care,[3,4] the pre-post differential increases in hospice use for enrolled veterans likely indicate improvements in the quality of veterans' end-of-life care. Studies from the VA's Veteran Experience Center, which monitors the quality of care for veterans who die in inpatient settings (hospitals and community living centers), show that bereaved family members' evaluations of end-of-life care have improved after implementation of the CELC Initiative: In FY 2008, 52 percent of families rated end-of-life care as excellent, compared to 58 percent in FY 2011—when another 24 percent rated the care as very good.[2] Also, the proportion of bereaved families who rated the care as excellent was 12 percentage points higher for veterans who died in a hospice bed, compared to those who died in another VA medical center bed.[2] Additionally, research has shown that receipt of VA palliative care[17] and care in VA inpatient units with higher staffing levels (consistent with the addition of hospice and palliative care staff)[18] is associated with higher bereaved family ratings of end-of-life care. These

data support the notion that the overall quality of veterans' end-of-life care has improved with increased enrollment in hospice.

The VA continues to build upon the improvements achieved through its CELC Initiative and to address remaining issues, such as the need for greater access for underutilizers of hospice and the need for timelier access to hospice and palliative care.[8,13] The largest challenge moving forward (since the CELC Initiative's targeted financial investments ended in September 2012) is the need to maintain momentum, given competing priorities (such as implementation of the Veterans Choice Act of 2014), while improving the care of veterans with serious illnesses—many of whom will choose hospice care inside or outside the VA.

## Conclusion

It appears that within a short period of time, the Comprehensive End of Life Care Initiative has been effective in increasing hospice use for older male enrolled veterans beyond that observed for nonveteran Medicare decedents. These differential increases over time were even larger among veterans who only used the VA, and the members of that group who had stays in hospitals (where substantial CELC Initiative investment occurred) in the last year of life. ■

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## NOTES


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12 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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*Original Article*

# Medicare Cost at End of Life

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**Abstract**

As the Medicare program struggles to control expenditures, there is increased focus on opportunities to manage patient populations more efficiently and at a lower cost. A major source of expense for the Medicare program is beneficiaries at end of life. Estimates of the percentage of Medicare costs that arise from patients in the last year of life differ, ranging from 13% to 25%, depending on methods and assumptions. We analyze the most recently available Medicare Limited Data Set to update prior studies of end-of-life costs and examine different methods of performing this calculation. Based upon these findings, we conclude that higher estimates that take into account the spending over the 12 months leading up to death more accurately reflect the full cost of a patient's last year of life. Comparing current year costs of decedents with Medicare's current year costs understates the full budgetary impact of end-of-life patients. Because risk-taking entities such as Medicare Advantage plans and Accountable Care Organizations (ACOs) need to reduce costs while improving the quality of care, they should initiate programs to better manage the care of patients with serious or advanced illness. We also calculate costs for beneficiaries dying in different settings and conclude that more effective use of palliative care and hospice benefits offers a lower cost, higher quality alternative for patients at end of life.

**Keywords**

medicare, end-of-life costs, hospice, palliative care, population management, inpatient

## Background

As the Medicare program struggles to control expenditures, there is increased focus on opportunities to manage patient populations more efficiently and at a lower cost. Patients at end of life (EOL) represent a disproportionate share of Medicare's costs, implying that these patients are an appropriate population for management by risk-taking Medicare entities such as Medicare Advantage plans and Accountable Care Organizations (ACOs), whose mission is to reduce cost as well as improve the quality of care. Because risk-taking entities need to reduce costs to share savings, they seek opportunities for more intense patient engagement and management. Actuaries, health economists, policy analysts, and health services researchers have studied expenditures at the EOL for Medicare decedents for more than 30 years. What is important from the perspective of managing patients and costs is that for patients at the EOL, alternative care pathways that involve palliative care are available which can result in higher quality of life at less cost.

The objectives of this article are 4-fold:

1. To summarize some of the main findings of previously published research articles on EOL expenditures and utilization patterns.
2. To propose an appropriate methodology for estimating the proportion of Medicare spending accounted for by patients at EOL that takes into account spending during the final year of life, not just at the time of death.
3. To investigate recent Medicare EOL expenditures using the most recent Medicare Limited Data Set (LDS) data for calendar year (CY) 2015 to 2016.
4. To model the opportunity for Medicare Advantage plans and Medicare Shared-savings Program (MSSP) ACOs to reduce cost of care for members in their final year of life while maintaining or improving care quality.

## Literature Review on EOL Costs

There is a considerable literature about EOL costs, delivery, and financing from different disciplines. To better understand

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EOL costs and utilization patterns, we summarize examples of different aspects, as well as some recent developments in palliative care, quality, and futile care.

Numerous articles on EOL costs show that a large proportion of Medicare expenditures occur during the last 6 months of life.[1-9] This phenomenon has continued for many years as the number of Medicare decedents has increased with the aging American population. Medicare expenditures for EOL have increased dramatically from 1983 to 2016, primarily because of the increase in the number of decedents. Other articles compare EOL expenditures in the United States to other countries[10,11] or focus on Medicare expenditures for specific diseases.[12-14] A recent development in the literature challenges the idea that EOL costs are responsible for a high percentage of health-care costs.[15] Below, we discuss methodological differences that could account for differences in estimated proportions. Utilization trends also affect Medicare expenditures and utilization patterns at the EOL, including a higher proportion of Medicare decedents electing hospice. In addition, an increasing proportion of Medicare decedents electing hospice are living longer than 6 months, and noncancer patients now constitute the majority of hospice patients.

### *Cost Savings*

Several researchers have studied the hypothesis that hospice care reduces Medicare expenditures.[16-18] Although the evidence is mixed, recent research challenges this hypothesis, although methodological issues make testing difficult.[19] Hospice eligibility is based upon a prognosis of 6 months or less, but predicting the remaining length of life for most terminally ill patients is difficult, especially for those with noncancer diagnoses. The Centers for Medicare and Medicaid Services (CMS) reimburses hospices on a per diem basis for all care related to the terminal prognosis, including nursing care, social services, spiritual care, medications, medical equipment, personal aides, volunteers, and bereavement services. Based upon a per diem payment system, patients with long lengths of stay in hospice are less likely to create savings.[20] The patient's diagnosis is an important variable.[21-25] Several innovative programs have been tried to alter the payment methods for the delivery of hospice services designed to improve the coordination of EOL care and better control of EOL costs. Descriptions of experimental and successful palliative care programs are provided in the March 2018 MedPAC report and several other references.[19,26-30] Finally, physicians have noted that some care, particularly in acute hospitals, is futile. Attempts to define, identify, and address such care is in its infancy.[26,31]

## Data/Methods

### *The Medicare 5% LDS Analytical File ("Medicare 5% File")*

For the purpose of understanding cost of care at the EOL, we perform analysis of the Medicare 5% file for the years 2015 and 2016. This file is a random sample of Medicare's claims for the 2 years, containing experience of approximately 2.9 million patients for each year. Approximately 30% of these patients are enrolled in managed care plans (Medicare Advantage Health Maintenance Organization [HMOs] and Preferred Provider Organization [PPOs]), leaving approximately 2.1 million beneficiaries enrolled in "traditional Medicare" and available for analysis. We exclude members who have <6 months of eligibility in any year. Our sample shows 259 000 of the 5.8 million total patients (including Medicare Advantage patients) died in 2015 to 2016, or 4.47%, a rate that is consistent with the Krumholz et al's study[32] and Medicare's published rate.

Deaths are assigned to a particular place of death based on the last service date. For deaths reported in the eligibility file, the service with the latest reported date determines the place of death. We calculated the Medicare expenditures for inpatient, outpatient, professional, emergency department, physician office visits, hospital outpatient visits, hospice, skilled mursing facility, home health, and durable medical supplies. Outpatient pharmaceutical data are not included in the 5% files, although inpatient and outpatient infused drugs are paid under Medicare Part B and are included.

## Results

### *Medicare Costs at EOL*

The share of Medicare's total costs represented by subpopulations helps identify areas of opportunity for program management. There is some controversy over the share of Medicare's cost that Medicare decedents represent. A defined period, usually the last 12 months of life, is essential for assessing the cost of EOL patients because of the exponential increase in cost in the last months of life (see, eg, Table 1). However, some comparisons are made on a calendar period basis, which (by definition) includes patients with differing life expectancies. A typical statistic is that 25% of all Medicare's annual costs are accounted for by decedents (Riley and Lubitz[1] based on 2006 Medicare payments). Cubanski et al in a 2016 Kaiser Family Foundation Data Note[33] report that "in 2014, beneficiaries who died at some point during the year accounted for 4% of all beneficiaries in traditional Medicare, but 13.5% of traditional Medicare spending . . . This estimate is lower than the 25% estimate cited earlier because it is based on Medicare spending for people who died at some point in a given CY (in this case, 2014), rather than the last 12 months of spending for people who died." Aldridge and Kelley[15] also challenge the traditional estimate from the perspective of total EOL spending in the population (not restricted to Medicare patients). They report 13% of total spending due to patients in the last year of life. French et al[34] compare international costs at EOL, reporting 8.5% for the United States. Finally, a recent article by Finkelstein et al,[35] using Medicare data from 2007 to 2008, reports that patients dying in 2008 accounted for 15% of total Medicare cost for that year. Whether total spending on EOL patients is 13% or closer to 25% matters in terms of the priority given to managing this subpopulation.

**Table 1.** Average Medicare Expenditures Prior to Death.

| Year | Place of Death | Place of Service: Inpatient | Carrier | Hospice | Outpatient | SNF | HHA | DME | Total | Members | % Place of Death |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Average Medicare expenditures 90 days prior to death (per decedent, per month) | | | | | | | | | | | |
| 2015 | Home | $807.95 | $410.63 | $30.13 | $311.63 | $248.71 | $88.67 | $117.01 | $2014.72 | 2592 | 4.5% |
| 2015 | Home health agency | $3541.09 | $1129.44 | $65.01 | $1064.56 | $962.87 | $1039.89 | $180.12 | $7982.98 | 1251 | 2.2% |
| 2015 | Hospice | $3984.60 | $1272.44 | $2048.64 | $1062.14 | $986.45 | $287.67 | $63.14 | $9705.09 | 26 924 | 46.6% |
| 2015 | Inpatient | $11 231.53 | $2476.00 | $61.66 | $1530.73 | $1072.00 | $286.44 | $88.30 | $16 746.66 | 14 462 | 25.0% |
| 2015 | Outpatient | $1712.01 | $852.84 | $47.11 | $1382.93 | $628.29 | $120.87 | $55.62 | $4799.68 | 9593 | 16.6% |
| 2015 | SNF | $7485.28 | $1905.60 | $63.02 | $1164.98 | $4134.56 | $231.27 | $37.75 | $15 022.45 | 2945 | 5.1% |
| 2015 | Subtotal | $5447.80 | $1494.59 | $984.06 | $1204.35 | $1075.27 | $264.15 | $71.84 | $10 542.06 | 57 767 | 100.0% |
| 2016 | Home | $711.86 | $364.74 | $39.86 | $285.47 | $228.63 | $78.15 | $106.93 | $1815.63 | 2332 | 4.1% |
| 2016 | Home health agency | $3533.62 | $1077.95 | $26.56 | $1000.65 | $856.60 | $1029.46 | $111.59 | $7636.43 | 1249 | 2.2% |
| 2016 | Hospice | $4148.12 | $1306.42 | $2176.84 | $1109.27 | $942.44 | $293.76 | $57.56 | $10 034.41 | 26 989 | 48.0% |
| 2016 | Inpatient | $11 615.17 | $2527.64 | $73.58 | $1598.92 | $1078.33 | $287.51 | $90.01 | $17 271.17 | 13 816 | 24.6% |
| 2016 | Outpatient | $1607.58 | $828.37 | $51.47 | $1388.16 | $574.70 | $127.75 | $49.15 | $4627.18 | 9201 | 16.4% |
| 2016 | SNF | $7281.36 | $1885.30 | $49.01 | $1276.51 | $4444.66 | $239.22 | $35.88 | $15 211.95 | 2674 | 4.8% |
| 2016 | Subtotal | $5559.16 | $1511.54 | $1075.31 | $1246.51 | $1050.63 | $269.88 | $66.37 | $10 779.41 | 56 261 | 100.0% |
| Average Medicare expenditures 180 days prior to death (per decedent, per month) | | | | | | | | | | | |
| 2015 | Home | $806.06 | $397.52 | $29.20 | $329.83 | $263.06 | $89.55 | $106.04 | $2021.24 | 2592 | 4.5% |
| 2015 | Home health agency | $2784.61 | $967.75 | $66.15 | $956.38 | $753.71 | $736.66 | $160.65 | $6425.93 | 1251 | 2.2% |
| 2015 | Hospice | $2723.59 | $1046.77 | $1331.48 | $1079.11 | $794.01 | $244.16 | $65.16 | $7284.28 | 26 924 | 46.6% |
| 2015 | Inpatient | $6596.72 | $1700.23 | $50.03 | $1368.61 | $802.04 | $230.94 | $86.65 | $10 835.21 | 14 462 | 25.0% |
| 2015 | Outpatient | $1404.19 | $706.89 | $41.93 | $1132.55 | $542.94 | $104.69 | $53.64 | $3986.84 | 9593 | 16.6% |
| 2015 | SNF | $4665.84 | $1346.00 | $48.70 | $1035.39 | $2449.90 | $206.48 | $45.15 | $9797.46 | 2945 | 5.1% |
| 2015 | Subtotal | $3488.42 | $1138.34 | $645.29 | $1121.95 | $814.05 | $219.50 | $71.51 | $7499.06 | 57 767 | 100.0% |
| 2016 | Home | $724.97 | $359.45 | $39.18 | $325.86 | $238.44 | $84.94 | $99.91 | $1872.74 | 2332 | 4.1% |
| 2016 | Home health agency | $2686.65 | $934.45 | $27.81 | $921.75 | $674.89 | $738.28 | $110.31 | $6094.14 | 1249 | 2.2% |
| 2016 | Hospice | $2826.87 | $1079.75 | $1407.14 | $1122.95 | $770.13 | $249.25 | $60.29 | $7516.38 | 26 989 | 48.0% |
| 2016 | Inpatient | $6810.05 | $1727.88 | $58.56 | $1444.93 | $800.33 | $229.60 | $91.13 | $11 162.49 | 13 816 | 24.6% |
| 2016 | Outpatient | $1292.79 | $684.30 | $43.57 | $1163.83 | $483.42 | $109.32 | $49.44 | $3826.66 | 9201 | 16.4% |
| 2016 | SNF | $4563.45 | $1343.12 | $43.92 | $1149.66 | $2593.48 | $215.89 | $44.30 | $9953.83 | 2674 | 4.8% |
| 2016 | Subtotal | $3546.43 | $1153.67 | $700.86 | $1172.47 | $793.16 | $224.00 | $68.08 | $7658.68 | 56 261 | 100.0% |

[a]Places of death of home includes professional and DME claims.
Abbreviations: SNF, skilled-nursing Facility; HHA, home health Agency; DME, durable medical equipment.

**Table 2.** Last 12 Months of Cost of Persons Dying in 2015.

| Costs in Year | Disposition | Total Allowed Amount | % of Total Cost |
|---|---|---|---|
| 2015 | 2015 survivor | $16 421 958 669 | 86.6% |
| 2015 | 2015 decedents | $2 535 371 134 | 13.4% |
| | Subtotal | $18 957 329 802 | 100.0% |
| 2014 | 2015 decedents | $1 204 327 168 | 6.4% |
| 2015 | Subtotal: 2015 decedents | $3 739 698 301 | 19.7% |
| 2015 | 2016 decedents | $1 165 667 047 | 6.1% |
| 2015 | Total 2015 cost | $17 791 662 755 | 93.9% |
| | 2015 decedents | $3 739 698 301 | 21.0% |

Medicare's cost in the last 12 months of EOL patients can be estimated on a current cost basis, by dividing the cost of those members who die in a year by Medicare's total cost in the year. As we show in Table 2, allowed cost for those members who died in 2015 is US$2.5 billion; total allowed cost for 2015 amounted to US$19.0 billion, resulting in a share of decedents of 13.4%. However, this current cost basis overlooks 2 important adjustments that are necessary to estimate accurately the cost of decedents that takes their final 12 months of costs into consideration:

1. Depending on the date of death in 2015, the last 12 months of a member's life will include some months in 2014. To estimate the percentage of cost represented by the last 12 months of life of 2015 decedents, it is necessary to add to the 2015 costs their cost in those months in 2014 that are part of the member's last 12 months. For 2014 decedents, these costs amount to US$1.4 billion. Without this adjustment, the cost of people dying in 2015 as a percentage of 2015 total costs

**Table 3.** Average Medicare Expenditures—Outliers Removed.

| Year | Inpatient | Carrier | Hospice | Outpatient | SNF | HHA | DME | Total | Members |
|---|---|---|---|---|---|---|---|---|---|
| PMPM 90 days prior to death—outliers removed | | | | | | | | | |
| 2015 | $5290.62 | $1465.97 | $983.70 | $1054.72 | $1072.38 | $264.04 | $50.26 | $10 181.71 | 57 767 |
| 2016 | $5400.69 | $1485.45 | $1075.28 | $1094.30 | $1045.47 | $269.72 | $42.80 | $10 413.72 | 56 261 |
| PMPM 180 days prior to death—outliers removed | | | | | | | | | |
| 2015 | $3378.66 | $1102.26 | $644.64 | $935.67 | $812.92 | $219.29 | $50.86 | $7144.31 | 57 767 |
| 2016 | 3440.19 | $117.98 | $700.80 | $980.45 | $790.83 | $223.73 | $45.92 | $7299.90 | 56 261 |

Abbreviations: SNF, skilled-nursing Facility; HHA, home health Agency; DME, durable medical equipment; PMPM, per member per month.

is 13.4%; adding the full 12 months of costs, the percentage rises to 19.7%.

2. In addition to adjusting the numerator of the percentage calculation, we also need to adjust the denominator. The cost of all members in 2015 is US$19.0 billion. At some point in 2016, some of those costs will be attributed to members who die in 2016. It is therefore appropriate to deduct the 2015 cost of 2016 decedents from the 2015 costs. We reduce the 2015 costs by this amount to reflect the total cost incurred by 2015 decedents and survivors.

With these 2 adjustments, the percentage of Medicare's cost represented by 2015 decedents rises to 21%. This percentage is somewhat lower than that reported by Riley and Lubitz based upon Medicare data between 1978 and 2006,[1] although these authors report a decreasing trend in EOL costs. The percentage is higher than that reported by other authors, likely because we include a full 12 months of final year expenses for decedents and defer the current year's final 12-month costs for those members who die in the following year.

## *Costs by Type of Service*

In order to model the opportunity for Medicare Advantage plans and MSSP ACOs through reducing the cost of EOL care, we investigate recent Medicare EOL expenditures by type of service, using the most recent Medicare LDS data for CY 2015 to 2016. Table 1 shows an analysis of Medicare's cost per decedent by type of service during the 90 and 180 days prior to death, according to the place of death.

Average Medicare expenditures per decedent per month are greater in the last 90 days preceding death versus the last 180 days preceding death, confirming the exponential increase in costs as death approaches. The highest spending occurs in acute hospitals. Care provided in skilled nursing, hospice, and home health care are other major sources of Medicare expenditures. An increasing proportion of Medicare decedents' final care is rendered by hospices. Average Medicare expenditures per decedent per month increased by 2% from 2015 to 2016.

It might be expected that the mean expenditure is influenced by "outliers," which we define as beneficiaries with Medicare expenditures above or below 3.0 × (Q3 − Q1), where (Q3 − Q1) is the interquartile range. However, the results shown in Table 3, when compared to Table 4, show relatively little effect on average Medicare payments of removing outliers, implying that people with very high costs are relatively few among all decedents.

**Table 4.** Study Population.[a]

| Sample Size Description | Member Count |
|---|---|
| 1. All members | 3 114 712 |
| 2. Non-Medicare advantage members | 2 129 432 |
| 3. Parts A and part B With >5 months of eligibility | 1 668 000 |
| 4. Final sample—Members dying between January 1, 2015, and December 31, 2016 | 114 028 |

**Table 5.** Average Cost per Day for Patients Dying in Hospital Compared with Cost per Day in Hospice.

| Days Prior to Death | Hospital Cost Per day | Hospice Cost Per day |
|---|---|---|
| 1-3 | $5983 | $230.74 |
| 4-7 | 638 | 230.74 |
| 8-20 | 493 | 190.55 |
| 21-40 | 349 | 190.55 |
| 41-60 | 267 | 190.55 |
| 60-90 | 220 | 190.55 |
| 90-130 | 184 | 190.55 |
| 130-180 | 156 | 190.55 |

Table 5 displays the average Medicare expenditures for patients treated in acute hospitals during the last 180 days of life, compared to the hospice per diem cost. The cost of patients treated in the inpatient setting far exceeds the per diem expenditure for palliative or hospice care. Key to the estimation of potential savings from earlier hospice referral is the reimbursement rates paid by CMS.[36] For Fiscal Year 2017 (October 2016 to September 2017), the base rate was US$190.55; for the last 7 days of life, this rate is boosted by a service intensity add-on of US$40.19. For the last 7 days of life, total reimbursement is US$230.74. Thus, savings are possible from admission to hospice within 90 days of death, based on the lower hospice reimbursement rate compared to the average cost of a patient who dies in hospital. With 25% of all Medicare beneficiaries dying in inpatient hospitals, the savings from increased hospice use could be considerable. One challenge, as described by Finkelstein et al,[35] is identifying patients who could be eligible for

hospice earlier. An additional challenge is educating patients and families about hospice benefits.

## Discussion

Numerous innovative programs and interventions are attempting to help CMS contain Medicare costs. One important statistic for program planning, however, is the ratio between the cost of a patient subpopulation and the number of patients. A relatively high ratio indicates a possible opportunity to reduce overall cost (subject to maintaining quality). Whether the ratio for EOL patients is 2.9 (13.0/4.5), 4.7 (21/4.5), or 5.6 (25/4.5) matters from the perspective of those who are responsible for managing the cost of the program (and particularly risk-taking entities such as MA plans and ACOs). Patients, clinicians, policy analysts, and administrators agree that the most important goal of EOL is to provide services that respect the wishes of the patient and his or her family. Palliative or hospice care can help to ensure that care is concordant with the preferences of patients and their caregivers while at the same time reducing Medicare expenditures. One critical challenge is to provide information to patients and caregivers at an appropriate juncture in a patient's care. A related challenge is to have a discussion between patients and families and providers about treatment options most likely to meet their EOL preferences.

Medicare expenditures increase sharply in the last few days of life, particularly for patients who die in hospital. Recent developments in hospice and palliative care offer the possibility of higher quality care at lower cost to Medicare if patients enter hospice earlier. Finding a lower cost site of care that does not jeopardize patients' wishes is a realistic, worthy goal. Expensive, futile care—especially given in an intensive care unit of an acute hospital—probably does not meet the preferences of most people at the end of life. Identifying those who will benefit from intensive care from those in which aggressive care is likely to be futile and burdensome is a challenge for providers, patients, and families. Published studies show that palliative care services can have a moderating effect on cost while improving quality of care. Examples of studies include the study by Lustbader et al, Center to Advance Palliative Care, and Pham and Krahn, and Smith et al.[37-40] The increased existence of hospital-based palliative care services and the recent development of community-based palliative care programs may help to ensure that care at the EOL is concordant with patient and family goals, while at the same reducing the cost of care.

## Conclusion

Beneficiaries at EOL account for a significant portion of Medicare spending. Comparing current year cost of decedents with Medicare's current year costs understates the full budgetary impact of EOL patients. Greater use of hospice and palliative care, with their lower cost per patient, offers the possibility of expense reduction to the Medicare program while also improving quality of life outcomes.

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